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ABSTRACT

This Congressional report contains the testimony provided at the first five days of hearings pertaining to the reauthorization of the Older Americans Act of 1965. The focus of the hearings was on amending those portions of the act dealing with: (1) grants for State and community programs on aging (Title III); (2) training, research, and discretionary programs and projects for older adults (Title IV); and (3) community service employment for older Americans (Title V). Included among those persons providing testimony at the Rhode Island hearings were representatives of the following agencies and organizations: Rhode Island Meals on Wheels, Inc.; the Visiting Nurse Service of Greater Woonsocket; Fruit Hill Day Center for the Elderly; the Southeast New England Long-Term Care Gerontology Center, Brown University; the American Association of Retired Persons; the National Council on Senior Citizens; the Senior Inn, Inc.; the University of Rhode Island; and Rhode Island College. The hearings in Washington, D.C. included testimony of representatives from: the American Federation of Home Health Agencies, Inc.; the American Mental Health Counselors Association; the New York State Office for the Aging; the National Homecaring Council, Inc.; the University of Kansas Long-Term Care Gerontology Center; the Urban Mass Transportation Administration; the National Association of Nutrition and Aging Services Programs; and the National Association of State Units on Aging. (A status report on Title IV of the Older Americans Act as amended and a discussion of types of technical assistance provided to the States by the Department of Labor are also included in this volume, as well as responses of witnesses to questions raised by the subcommittee chairman.) (MN)

S. Hrg. 98-945, Pt. 1

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

ED253745

HEARINGS

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

REAUTHORIZATION OF THE FOLLOWING SECTIONS OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED: TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING; TITLE IV—TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS; AND, TITLE V—COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

JANUARY 17, 1984
NORTH PROVIDENCE, RI

JANUARY 31; FEBRUARY 24 AND 28; AND MARCH 13, 1984
WASHINGTON, DC

PART 1

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REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

TUESDAY, JANUARY 17, 1984

U.S. Senate,
Subcommittee on Aging,
Committee on Labor and Human Resources,
North Providence, RI.

The subcommittee met, pursuant to notice, at 9:30 a.m., at the North Providence Senior Center, 2240 Mineral Spring Avenue, North Providence, RI, Senator Claiborne Pell presiding pro tempore.

Present: Senator Pell.

Senator **Pell**. This is a hearing of the Senate Subcommittee on Aging, and before commencing the substance of the hearing, we have with us the mayor of North Providence, Mayor Mancini, and I would ask him to speak at this time.

STATEMENT OF HON. SALVATORE MANCINI, MAYOR OF THE TOWN OF NORTH PROVIDENCE, RI

Mayor **Mancini**. Good morning, Mr. Pell, our senior citizens of the town of North Providence, and throughout the State of Rhode Island. I would like to welcome all of you here in this great town of North Providence this morning for this hearing; and I would like to thank Senator Pell, our senior Senator, for affording us the opportunity of having the hearing in the State of Rhode Island; and from what I understand, this will be the only hearing out of Washington. And, Senator, for that I would like to thank you; and, of course, on behalf of all our citizens, we would like to thank you for what you have done for us in the years that you have served as our Senator. Again, I don't know how I could express it more to you to show our appreciation for the fact that you are here this morning in the town of North Providence and in the State of Rhode Island, to show us and to give us the opportunity to state our case on the aging.

Now, I would like to introduce to you our senior Senator, our great Senator, Senator Claiborne Pell.

Senator **Pell**. I thank Mayor Mancini very much for his introduction of me in this his home territory and his home bailiwick.

If you can't hear us, either me or the witnesses, wave your hands and we will speak up. If you can hear us, if I don't see your hand waving, I will presume that you can hear us.

This is, as I said, a hearing by the Subcommittee on Aging of the Senate. My colleagues in the Congress from Rhode Island were all invited. I understand we are fortunate that Congresswoman Schneider has a representative here, and Congressman St Germain regretted not being here and submitted a statement, and with his consent I will ask that his statement be inserted in full in the record, and I am very grateful to Congressman St Germain for such a strong supportive statement.

[The following was received for the record:]

JAN [illegible]

STATEMENT OF CONGRESSMAN FERNAND J. ST GERMAIN AT A HEARING OF THE SENATE SUBCOMMITTEE ON AGING AT THE NORTH PROVIDENCE SENIOR CENTER, JANUARY 17, 1984.

I am pleased that the citizens of Rhode Island have been offered this opportunity to express their views on the reauthorization of the Older Americans Act before Congress undertakes this task in 1984.

According to census figures, Rhode Island ranks very high in the percentage of elderly in the population. Consequently, the programs established through the Older Americans Act are especially important in our state. Broadly speaking, the Older Americans Act gives authority to state and area agencies on aging to concern themselves with all aspects of the lives of the elderly, from assuring that basic nutritional and housing needs are met, to utilizing the special talents and experience of the elderly, to serving as advocates for the elderly in all circumstances. It also provides support for training, research, and demonstration projects in the field of aging.

As we begin to consider the reauthorization of the Older Americans Act, it is important that we hear from those who are concerned with the day-to-day functioning of the programs, both as operators of the programs and as recipients of the various benefits which the programs provide. The current Administration has made a practice of attempting to reduce expenditures for social services. It is my belief that the programs which fall under the Older American Act should not be cut back and I hope that testimony at today's hearing will demonstrate the good which these programs have done and will bring to light ways in which they might be improved. Because of Rhode Island's very high percentage of elderly people, our experiences should serve as a touchstone as national policy is formulated.

We must concern ourselves today, and over the coming months, with several questions. Are the needs of our senior citizens being met? If not, why not? We know that the percentage of elderly in our population is growing. Will this bring special problems to society? If so, how can these problems be solved? Are the programs currently existing sufficient? Do existing programs need to be expanded or is there a need for new programs and new approaches?

We come to this hearing to provide an opportunity for the experts, those who work with these programs every day, a chance to share their expertise, so that when Congress takes a look at the reauthorization of this law which affects so many of our people, improvements can be made which will make the programs even more responsive to existing needs.

I look forward to reviewing your remarks and gaining the insight which you will share today.

OPENING STATEMENT OF SENATOR PELL

Senator PELL. The hearing today is one that we have been working on and planning for some time, and I welcome all my fellow Rhode Islanders here today to learn more about the Older Americans Act and its impact on our lives. Here I speak to all of us who are in this room because the Older Americans Act, which is up for reauthorization, is a very significant act in our Nation's history. The proceeding this morning is that of a formal hearing with the stenographer coming up from Washington, and this is a hearing of the subcommittee of the full committee. For that reason we will follow the rules of the committee and of the Senate, and the witnesses as they come will have their statements and we will go back and forth, and I will try to make sure at the end of the hearing there will be an opportunity for questions from the audience. It will depend on how quickly we move along; and in this regard, I must ask the witnesses to try to limit their oral testimony to 5 minutes. We will put into the record the full written text of everything that is submitted.

The Subcommittee on Aging, of which I am a member, has the responsibility in the Senate for the Older Americans Act which provides funds for senior centers, senior meal sites, Meals on Wheels, senior community service jobs, and a variety of other services. I would add here that this hearing is being held thanks to the courtesy of the majority member who is chairman of the subcommittee, Senator Grassley of Iowa. He is the chairman of our subcommittee, and he is being kind enough while not being able to come himself of sending up Mr. Peter Conroy who is with us today representing the majority.

As you can see, this is a nonpartisan hearing, a hearing trying to examine the problems of our elderly citizens and what we can do about them in the best interest of our country. This committee, on which I have served now for 23 years, has the responsibility for examining the various factors or conditions that can be improved to help our senior citizens. As Mayor Mancini pointed out, this is the only scheduled hearing on the reauthorization of the Older Americans Act being held outside of Washington.

As you know, the Older Americans Act has a singular Rhode Island connection in that Congressman John E. Fogarty was the one who helped initiate it in the beginning in the Congress. So it is very appropriate that we should carry on this way in his old district and recognize his contribution.

Rhode Island ranks third in the country when it comes to the number of senior citizens, those who are over 55. Almost 25 percent of our Rhode Islanders are over 55 years of age. For this reason, the reauthorization has particular significance to us.

When the Older Americans Act was created in 1965, there were only about 180,000 Rhode Islanders over 55. Now, 15 years later, that number has grown to more than 230,000 or it's increased by 50,000. In other words, we have 50,000 more older citizens in our State today than we had 15 years ago, and yet the total population of the State has held even or declined, even declined a bit. So you can see the difficulties we have.

President Kennedy's message to Congress many years ago called for services to the elderly, trained personnel, and senior recreation centers. Today you find that Rhode Island has 40 separate centers, 53 meal sites, a Meals on Wheels Program that covers the entire State; and last year 18,000 Rhode Islanders took part in the meal site program.

In addition, transportation, part-time senior community service jobs, and many other services are available. And this morning we are going to be listening to actual senior citizens, advocates, and experts on what the Older Americans Act does for Rhode Islanders now and what changes should be made in the legislation when it comes up for reauthorization. I am sure that many of you will have ideas, and I would hope these ideas will be expressed before the morning's out if not by you, by somebody with the same viewpoint because the important thing is that the idea be expressed.

Finally, when we are talking about senior citizens, I, too, am a senior citizen, and I have my RIPTA bus pass with me. So I know your aches because your aches are my aches and vice versa.

Now, our first witnesses that we have representing the senior citizens themselves, Elsie Jackson and Helen Smith, both of Newport. If they would come on up here and share this microphone right here, I would be very appreciative. I would add here Beatrice Ward of North Providence. Could you come forward, please. Since this is the home territory of Beatrice Ward of North Providence, we will ask Mrs. Ward if she would start out, and hold the microphone very, very close to you.

STATEMENT OF BEATRICE WARD, NORTH PROVIDENCE, RI

Miss **Ward**. How's that? It is with a deep sense of gratitude I wish to acknowledge the various branches of government, the National, State, local levels, for all the support given in developing worthwhile programs for the elderly.

Now, 6 years ago a very unusual experience presented itself to me within the walls of the old fire station, a historical site in North Providence. That was where the senior center, this senior center, was first housed; and within those welcoming walls I found myself having a vote taken for a bus pass, just like you, Senator. While making a quiet exit, a very inviting voice said, "Excuse me. You are the ladies I have been trying to contact."

Well, the ladies involved were my sister and I. It was none other than your dear director, Corinne, who immediately told of her needs. Guess what the needs were? Well, instructors were needed for the humanities program. Needless to say, we left the building with unit books fresh from Washington under our arms.

This special appointment was a most interesting challenge for us since we had just entered a field of adjustment. After 36 to 38 years of teaching and counseling at the academic level, what a welcome experience to work with a group of 30 senior citizens who were truly hungry for knowledge pertaining to the humanities program covering history, literature, poetry, the arts, and various cultures. Within the first year, this enthusiastic group representing various interests and careers cared and shared their very well defined needs and wants. Very modestly members began to creatively express themselves through prose and poetry. Their volumes are used at the center and appreciated by those in and out of the classroom. Even to a writers guild response. A most stimulating experience for the class and leaders was that of being a test site in establishing a unit of work for Washington to be used throughout the country.

Now the big question. How did this experience affect my approach to a life change? Answer. I had much to gain from just being one of the group and not at the teacher's desk. Comradeship was so evident, all worked together to know more about world affairs from a positive approach. Appreciating all age levels under the heading of caring and sharing has developed into an intergenerational project working closely with the faculty and students from the North Providence High School, an excellent rapport is evident while intermingling in the classroom. An outreach of this project includes the class raising funds covering two $500 scholarships for those specializing in gerontology.

Because caring and sharing is an important part of my life, certain days you will find me enjoying the center's dishwasher in the meal site.

In closing, a very big sincere thank you to Corinne, the staff members, and my sister for all the wonderfully warm understanding they have given me. Three cheers for all the caring and sharing so evident in this center.

Senator **Pell**. Thank you very much indeed, Beatrice Ward, for that touching and moving statement. Now from my home city of Newport, Elsie Jackson.

STATEMENT OF ELSIE JACKSON, NEWPORT, RI

Ms. **Jackson**. I would just like to say if it wasn't for New Visions, I don't know what I would do because I have no way of getting around unless New Visions comes to pick me up. And the meal site is a great help. I don't have to cook every single day. I go down about 4 days a week for my lunch which is a saving to me. And I enjoy it very much. So I would hate to see either one of these programs canceled. Thank you.

Senator **Pell**. And now we have also from Newport Ms. Helen Smith.

STATEMENT OF HELEN SMITH, NEWPORT, RI

Ms. **Smith**. Well, I represent the Hillside Senior Citizens in Park Home. And I will say we come from a small group but a very successful group, and we have some wonderful workers and we give our credit to Florence Gray and Lucy and also Edith Wright. And for them we have a lot to be thankful for because I go down there when weather is permissible and I have my meals and we also have a bingo—I better not say that because we might get fined, but we only play for things that we bring in. Then we make a lot of nice things. We have our sales and we have our fairs, and we're a happy group. You know what I mean? It gets you out of the house and among friends that you wouldn't know if you didn't go down there.

So I think we have lots to be thankful for, for our senior citizens and for the volunteers that help to make it a day, and I thank everyone for inviting us here today. I have got a cold.

And I would like to say I know Senator Pell since he was a little boy because I belong to Trinity Church, and my husband used to deliver fish at his family home, Eddie Smith.

Senator **Pell**. Right.

Ms. **Smith**. Do you remember Eddie? And he used to say he remembers you when you were in knickerbockers, right?

Senator **Pell**. I still have some.

Ms. **Smith**. Only you wear leg warmers now, right.

Senator **Pell**. Thank you very, very much for your testimony, and thank you for being with us, all of you. Ms. Smith, thank you.

Ms. **Smith**. As usual, I have got a cold.

Senator **Pell**. Now, our next witnesses are Mrs. Anna Tucker, director of the department of elderly affairs; and Mrs. Anna Prior, chairwoman of the Governor's Advisory Committee on Aging. I am very glad to have with us Mrs. Tucker and Mrs. Prior, and we will start out with Mrs. Tucker who is the director of the Rhode Island Department of Elderly Affairs since it was first created as a separate department 7 years ago. She also served in the Rhode Island Department of Labor for 34 years, holding several posts, including those of chief of labor standards and executive director of the Governor's Advisory Commission on Women. She is a leading authority in New England on aging issues and respected and liked by all those who work with her and come in contact with her. Mrs. Tucker.

STATEMENT OF ANNA M. TUCKER, DIRECTOR OF RHODE ISLAND DEPARTMENT OF ELDERLY AFFAIRS

Mrs. **Tucker**. Thank you very much, Senator Pell. This is indeed a pleasure to have you in Rhode Island for this hearing. Senator Pell has been a champion for our older citizens, and we are certainly proud that he represents Rhode Island in Washington.

We are here today to reflect on the Older Americans Act passed in 1965, 19 years ago. It has been 19 years of constant growth, development, learning, and change. Those who were involved in the passage of this act in 1965 could never have imagined the impact the Older Americans Act would have on services for older persons, on the lives of older persons, and on our communities and States. Who could have imagined that in Rhode Island the nutrition program would grow to an annual total of over 1,050,000 meals. Who could have envisioned multipurpose senior center facilities that are safe, adequate, and comfortable for our older people.

We have learned some very valuable lessons over a period of 19 years. We have developed standards for our programs, and we have become fiscally and programatically accountable. We have come to realize that the needs of our older citizens and the way we address these needs cannot be viewed in isolation. We have come to realize that what we must do is begin with people and their needs and from there provide them with service options. Options that allow our older citizens to choose their own life style and to continue to live in this style as long as possible.

The Older Americans Act has provided the framework and funding to enable a partnership between Federal and State government, local government, and the communities. This partnership is evident in the enormous resources that have been generated at the local level in support of these programs. This partnership is the reason for the enormous volunteer commitment that has always been evident in these programs, and that partnership is felt by older persons who participate in our programs both in time, commitment, and actual cash contributions toward services.

The reauthorization of the Older Americans Act gives us an opportunity to strengthen this partnership. The department of elderly affairs would like the U.S. Congress to consider the following issues in this reauthorization.

One, we propose that separate authorizations be maintained for title III-B and III-C. The 20-percent transfer from one title to the other has afforded the States great flexibility in the funding of services. This 20-percent transfer should be retained.

Two, we propose that title IV-A training funds be restored to their previous funding level.

Three, we propose that title V Senior Employment Program be moved to the Administration on Aging. It now is in the Labor Department. We further propose that funds under this program should be allocated on a formula basis to the States as are other funds in the act.

Four, we propose that language regarding community focal points on aging be strengthened. The focal point concept is a key to the access of service options for our older citizens.

Five, we propose that language regarding the role of advocacy in the Older Americans Act be strengthened. Advocacy is the key to seeing that the partnership that I previously mentioned will continue.

Six, we propose that the U.S. Department of Agriculture program be cashed out and moved to the Administration on Aging.

Seven, we propose that the wording in the Older Americans Act restricting awards to senior centers for compensation of professional and technical staff be eliminated. This wording places a restriction on the types of costs that can be covered by AOA funds in senior center grants. This restriction does not exist for any other type of service and can severely restrict the ability to mobilize local resources in support of senior center programs. We strongly urge that this language be amended.

Eight, we propose that administrative funds be allocated to states based on a percentage of title III funds but not less than a minimum of $400,000 annually. Rhode Island, a minimum level State for administrative funds, has not received an increase since 1979.

Nine, we propose that language regarding targeting of services be retained. We feel strongly that the American dream to own a home and remain independent in the community should not be sacrificed at age 65 or because of the loss of a spouse. An older person whose income is so marginal that they are unable to maintain their home and afford proper nutrition is truly vulnerable, and should be targeted for services under the Older Americans Act. By this I mean these are the people who are just above income and are not eligible for any of the programs.

Where will the future of the Older Americans Act take us? Certainly, we must consider the changes in our older population. As persons live to more advanced ages, they need various services and different kinds of services, and I hope that the aging network will approach this challenge by offering options for continued independence that fit the person in need rather than the agency providing the service.

Over the years, the total number of older persons will continue to grow. We have found that we must respond to various needs of persons ranging in age from 60 to 100-plus. We must keep the flexibility to meet this challenge and the clear direction and sense of priorities to target those who are vulnerable and at risk.

We cannot allow our older persons to be heard only on issues that involve senior citizens. We must continue to maintain them in the mainstream of our society, and our voices can and must be heard on all issues.

I would like to add a few final words on the Older Americans Act role in long-term care. Whether we knew or intended it to be so, Older Americans Act services have been involved in long-term care since day one. Services such as home-delivered meals, elderly day care, specialized transportation, are all integral parts of the continuum of services that make up long-term care. I do not anticipate that the Older Americans Act Fund should become involved in the direct provision of most services that are traditionally thought of as long-term care. Other Federal agencies have billions of dollars appropriated for such services. AOA's funds are a pittance compared to the size of some of these programs. My fear is that AOA funds could be swallowed up in the enormity of these programs at the expense of those services AOA now funds.

I suggest that AOA's impact can most effectively be felt in a preventive way. We must concentrate on our vulnerable, at-risk persons before their needs become massive and extremely expensive. Health, consumer and nutrition education are essential and are the appropriate role of AOA programs. The aging network can provide gap-filling services to foster continued independence.

I would like to again thank Senator Pell and the Subcommittee on Aging for coming to Rhode Island and listening to our concerns. The beautiful center we meet in today and the active and knowledgeable seniors who are with us attest to the fact that the Older Americans Act is alive and well in Rhode Island. We entrust its care to you in the reauthorization and pledge our continued cooperation and support. Thank you, Senator Pell.

[The prepared statement of Mrs. Tucker follows:]

SENATE SUBCOMMITTEE ON AGING
REAUTHORIZATION OF THE OLDER AMERICANS ACT

January 17, 1984

Submitted by: Anna M. Tucker, Director
RI Department of Elderly Affairs

I would like to begin by welcoming the members of the Senate Subcommittee on Aging to the State of Rhode Island, and I would particularly like to thank Senator Pell for his efforts in arranging this hearing in our State. Senator Pell has been a champion for the rights of our older citizens and the State of Rhode Island is proud that he is our Senator.

We are here today to reflect on the Older Americans Act, passed in 1965 - 19 years ago. It has been 19 years of constant growth, development, learning, and change. Those who were involved in the passage of this act in 1965 could never have imagined the enormous impact the Older Americans Act would have on services for older persons, on the lives of older persons, and on our communities and states, as well. We have seen major additions to the Older Americans Act over the years, including amendments establishing the Senior Nutrition Program. Who could have imagined that in the State of Rhode Island this program would grow to an annual total of over 1,050,000 meals. The amendments establishing funding for multi-purpose senior center facilities has enabled safe, adequate, and comfortable senior center buildings that our older citizens deserve.

I am proud to say that we have gotten smarter over these 19 years. The professional growth of persons in the Aging Network has been enormous, and we have learned some very valuable lessons:

- We have developed standards for our programs that serve the elderly and we have become fiscally and programmatically accountable. The quality of our program management has truly improved, and with it, the quality of our services.

- We have come to realize that the needs of our older citizens, and the ways we address these needs, cannot be viewed in isolation. We have come to recognize our older citizens as a part of the family unit, our Aging Services as a part of the Human Services System, and our Aging Network as a part of the social and political communities in which we live.

- We have come to realize that our role as service providers must, and is, changing. In the past, we have too often initiated an agenda of services and fit our clients or participants to the services. We have seen services as something we provide to and for clients.

  We have come to realize that what we must do is begin with people, and their needs, and from there provide them with service options. Options that allow our older citizens to choose their own life style and continue to live in this style for as long as possible. This is not an easy task, and it will continue to be one of the Aging Network's greatest challenges over the coming years.

The Older Americans Act has provided the framework and the funding to enable a partnership between Federal and State Government, local government, and communities. This partnership is evident in the enormous resources that have been generated at the local level in support of Older Americans Act programs. This partnership is the reason for the enormous volunteer commitment that has always been evident in Older Americans Act programs.

And this partnership is felt by the older persons who participate in our programs, both in time, commitment, and actual cash contributions toward services.

The reauthorization of the Older Americans Act gives us the opportunity to strengthen this partnership, to respond to changes in our aging population, and to ensure that our growth and development will continue.

The Department of Elderly Affairs would like the U.S. Congress to consider the following issues in this reauthorization:

1. We propose that seperate authorizations be maintained for Titles III-B and III-C. The 20% transfer from one title to the other, has afforded the states great flexibility in the funding of services. This 20% transfer should be retained.

We do not support the merging of III-B and III-C because we see a fundamental difference in the two sections. Title III-C funding for nutrition programs is intended to be on-going support for a specific service which requires years of capital expense and development. Title III-B funding is designed to be the catalyst for a network of social and supportive services. Development of local resources and on-going local support is critical for III-B services. States must ensure that these funds do not become static, but continue to afford the opportunity for change.

The Department of Elderly Affairs feels that these special purposes of III-B and III-C can best be served by retaining their separate authorizations.

2. We propose that Title IV-A training funds be restored to their previous funding level. On-going training initiative is essential in a field where such rapid change and growth is experienced. The most effective and efficient use of our limited resources cannot be ensured without adequately trained staff.

3. We propose that the Title V Senior Employment Program be moved to the Administration on Aging. We further propose that funds under this part should be allocated on a formula basis to the States, as are funds under III-B and III-C. Employment is a critical area of concern for our older citizens. We cannot ensure coordination with the Aging Network if this program remains outside the realm of the State Plan on Aging.

4. We propose that language regarding Community Focal Points on Aging be strengthened. The Focal Point concept is a key to the access of service options by our older citizens. In addition, the Focal Point can, and should be, the Aging Network made visible in the community.

5. We propose that language regarding the role of advocacy in the Older Americans Act be strengthened. One of the greatest contributions that can be made by a State Unit on Aging is to be an effective advocate for older citizens in dealing with local, state, and other Federal programs. Funding under the Older Americans Act could never be increased enough to address our older persons' needs, alone. Advocacy is the key to seeing that the partnership I mentioned earlier will continue.

6. We propose that the United States Department of Agriculture Program be cashed out and moved to the Administration on Aging. However, we suggest this with two important qualifications:
   a) That the per-meal incentive that presently exists in this program be retained, as it is truly a positive reinforcement for states to improve the Nutrition Program.
   b) That a cooperative agreement continue to exist between AoA and USDA to allow states to purchase USDA commodities from USDA where this purchase will result in a savings to the Nutrition Program.

7. We propose that wording in the Older Americans Act restricting awards to Senior Centers for the compensation of professional and technical staff be eliminated. This wording places a restriction on the types of costs that can be covered by AoA funds in Senior Center grants. This restriction does not exist for any other type of service and can severely restrict the ability to mobilize local resources in support of Senior Center programs. We strongly urge that this language be amended.

8. We propose that Administrative funds be allocated to states based on a percentage of Title III funds awarded, but not less than a minimum of $400,000 annually. The administration of the State Plan on Aging requires qualified, full time staff. As a minimum level State, Rhode Island has not received an increase in administrative funds since 1979 . Unless these administrative funds keep pace with the growth of responsibility under the Older Americans Act, the effective and efficient administration of this program cannot be assured.

9. We propose that language regarding targeting of services be retained. However, the Department of Elderly Affairs would like to see the concept of targeting defined to include vulnerable older persons who are at risk of loosing independence. This concept includes those who

> are now considered economically and socially disadvantaged. However, we feel that there are many in our older population who should be targeted, and are not presently included in this definition. The frail older person, the older person with mental health difficulties, the older home owner who is ineligible for categorical programs, but who, in reality, has a much lower income than many persons in subsidized housing who receive multiple benefits.

We feel very strongly that the American Dream to own a home, and remain independent in the community should not be sacrificed at age 65,or because of the loss of a spouse. Our older persons have worked hard to attain their goals. An older person whose income is so marginal that they are unable to maintain their home and afford proper nutrition is truly vulnerable, and should be targeted for services under the Older Americans Act.

Our programs have been unique because there has not been means testing. AoA programs have not been categorical and we hope they never will be. We can only hope to minimize those in greatest poverty by utilizing our resources in a preventative manner to keep vulnerable persons from becoming poor.

Where will the future of the Older Americans Act take us?

Certainly, we must consider the changes in our older population. As persons live to more advanced ages, more in-home services will be necessary. We already see this trend in the rapid growth of the Home Delivered Meals Program.

I hope that the Aging Network will approach this challenge by offering options for continued independence that fit the person in need, rather than the agency providing the service.

Over the coming years, the total numbers of older persons will continue to grow. We have found that we must respond to the various needs of persons ranging from 60 to 100+. We must keep the flexibility to meet this challenge and the clear direction and sense of priorities to target those who are vulnerable and at risk.

The numbers of older persons, and the projections for the future, are frightening, indeed. Those of us in the Aging Network must strive to keep our older citizens in the mainstream of our communities. We cannot let our growing numbers isolate our older population, for isolation will foster ignorance and resentment. Our older citizens must continue to demonstrate that they give tenfold for what they receive.

We cannot allow our older persons to be heard only on issues that involve senior citizens. We continue to be in the mainstream of our society, and our voice can and must be heard on all issues.

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I would like to add a few final words on the Older Americans Act's role in Long Term Care. Whether we knew or intended it to be so, Older Americans Act services have been involved in Long Term Care since day one. Services such as home delivered meals, elderly day care, specialized transportation, are all integral parts of the continuum of services that make up Long Term Care.

Certainly our understanding in this area has greatly developed over the years.

The Aging Network must begin to reevaluate its role in the Long Term Care System. I feel that the Aging Network's role in Advocacy, providing Community Focal Points, and research and demonstration can be key to meeting the Long Term Care needs of our Older Citizens. I do not anticipate that Older Americans Act funds should become involved in the direct provision of most services that are traditionally thought of as Long Term Care. Other Federal agencies have billions of dollars appropriated for such services. AoA's funds are a pittance compared to the size of some of these programs. My fear is that AoA funds could be swallowed up in the enormity of these programs at the expense of those services AoA now funds.

I suggest that AoA's impact can most effectively be felt in a preventative way. We must concentrate on our vulnerable, at risk persons before their needs become massive and extremely expensive. Health, consumer & nutrition education, are essential, and are the appropriate role of AoA programs. The Aging Network can provide gap filling services to foster continued independence. AoA services can be more responsive and more flexible than services which are primarily categorical and are often not community based. And AoA programs, through Community Focal Points, can enlist local resources towards these goals in a highly successful manner.

I would like to again thank the Sub-Committee on Aging for coming to Rhode Island and listening to our concerns. The beautiful Center we meet in today, and the active and knowledgeable seniors who are with us, attest to the fact that the Older Americans Act is alive and well in Rhode Island. We entrust it's care to you in the reauthorization, and pledge our continued cooperation and support.

Senator PELL. Thank you very much indeed, Mrs. Tucker. Now I would like you to hear from Anna Prior, who is the chairperson of the Governor's Advisory Committee on Aging for the past 4 years, chairwoman of the Rhode Island Consumer Council for the past 3 years, and has been chairperson for the Governor's Biennial Conference on Aging in the past two sessions, and was my senior intern 1½ years ago and contributed a lot to our work in Washington. Anna Prior.

STATEMENT OF ANNA PRIOR, CHAIRWOMAN OF THE GOVERNOR'S ADVISORY COMMITTEE ON AGING

Miss PRIOR. Thank you, Senator Pell, and David, and all the beautiful older Rhode Islanders who came out today.

There were 25 million people 65 years of age or older in America in 1980. They made up 11 percent of the population. By the year 2000, it is expected that there will be 36 million or 13 percent. The age group 75 and older or the old, old segment, is increasing faster than any other portion of the elderly population. Many will be female and living alone.

Longer lifespans then have led to a need to rethink many of the policies that are acceptable today in an attempt to meet the problems that come with old age. If people are to live 15 to 20 years longer, we must do more, not less, to enhance their lives. Some programs now in place must be expanded and adequately funded. The status quo would in reality be a cut because of the rapidly growing numbers of elderly persons to be served.

I suggest that Congress should plan and plan well for aging persons who will need the assistance to compete with other age groups in our society. The time is now when concern should be shown for the quality of life that future numbers of elderly will deserve.

Therefore, I respectfully request that special attention be paid to: One, under the Older Americans Act there should, in my opinion, be an updating of skills for those who are hired or volunteer to work with or advocate for aging persons in professional or paraprofessional ways. It is hoped that Congress will see fit to expand the present training program. There is sometimes a lack of communication between agencies of government and citizens requiring information or direction. Such conditions could be corrected with adequate ongoing training programs.

Two, it is my opinion that there is a glaring need for protective services for elderly persons in Rhode Island. The ombudsmen and the person in charge of legal services are restricted under present guidelines in the ways that they can act in attempts to aid elderly persons with legal, nursing home, or other problems. These knowledgeable persons cannot influence State legislative action. Radical changes in medicare, medicaid, alone prompt me to urge the ombudsmen and the legal service persons be given more power, not less, as some are suggesting, to effectively advocate for elderly persons.

Three, it has been proposed that cuts could be made in title V which allows for employment programs for elderly persons who live on small incomes. I suggest that this valuable program be broadened to help more of us cope with today's economy. Through the provisions of the Older Americans Act, many Rhode Islanders have benefited greatly. Certainly I support its extension, and I am very grateful for this opportunity to testify at this hearing. Thank you.

Senator **Pell**. Thank you very much indeed for your specific suggestions. Please wait because I have a couple questions, if I may.

Mrs. **Prior**. Yes, sir.

Senator **Pell**. For your very specific suggestions, because this is what's a help to us in Washington, to bring out round from the whole country the specific suggestions there are. And I would add here that when it comes to questions in behalf of both absent members of the committee and the chairman, Senator Grassley, any questions that Peter Conroy has that he feels should be submitted to witnesses, I will; and I want to say how grateful I am. He is sitting way in the back of the room. He really is the senior man on this subcommittee. Anyway, I understand that's where you wanted to be, but we are very grateful that you are here for the senior staff man for this whole operation. David Neumeyer, who helps me so much in this, will also follow up with any questions that he might have and I am very grateful to both these men who really make the Senate go round.

Now, Mrs. Tucker, just for a moment, what would life be like for our older Rhode Islanders if we didn't have the Older Americans Act? Is there any other way of filling the gap there?

Mrs. **Tucker**. I would like to say that we do have a very strong commitment from our State legislature and from the executive branch. Our Federal dollars under the Older Americans Act are $3,800,000 and under the State appropriation $2,866,000. There is no way that we could obtain State funding, there is no way that we would obtain local funding without Older Americans Act money to seed this program and to get the program started.

In addition to this, what the senior citizens do in Rhode Island is fantastic with their cash contributions, with their fundraising; and all of this is that partnership that I talked about, the Federal Government, the State government, the local government, and the senior citizens themselves in the communities they live in. This is a very important concept that only through the Older Americans Act has that worked.

Senator **Pell**. Thank you. Now, you mentioned too, Mrs. Tucker, in your testimony that very often we have tried to fit seniors to the services we have created rather than tailoring the services to the needs of the seniors. Could you give me an example of—one or two examples—of what you are driving at?

Mrs. **Tucker**. In Rhode Island in 1978 we did do a needs analysis. We sent out a survey to thousands of people. We just this year completed another needs analysis, Senator Pell, and we sent out 8,000 surveys. From those surveys we will respond to what Rhode Islanders need.

Nineteen years ago when the Older Americans Act money became available, we found senior centers in basements, we found them in social clubs, we found them in places that we do not want our senior citizens to go to. Now after 19 years we see beautiful centers such as this, and this is the way it should be.

Senator Pell. Now, among the training that is being produced here, I would be interested in what particular training you think is important. You mentioned that you wanted to increase funds for training. What kind of training are you thinking of?

Mrs. Tucker. I am thinking particularly of the technology and computer age. On January 26, we will be having a training session for our aging network in this particular area. This is a new area, and we need to get involved in computers and serve our elderly people in a better manner.

Senator Pell. I think these needs would be met by the proposed Older Americans Vocational Educational Act which I hope might be adopted on a national level and supported across the country. The idea here is that you should take people who are over 45 or 50 who have lost their jobs for no fault of their own and still have many working years left and would like to learn something new.

Mrs. Tucker. Senator Pell was in Rhode Island for a press release, I believe it was 6 months, 1 year ago, and it was at the Ocean State Training Center, and we met in a room where the computers were lined up against the wall, and the last man at the computer was a man 63 years of age who had lost his job and was being retrained. One of the reporters came to him and said, "Are you going to make it," and he said: "Positively I am going to make it." But this is a man 63 years of age who is in the computer field, a brandnew field to him, but he was going to make it. I think it is very important, Senator Pell, and also the Job Training and Partnership Act where 3 percent of that funding has been allocated for older people. This is the first time under the CETA Program there was a commitment to provide money for older people, but not set aside.

This is very important that set-asides for older people be established in all kinds of programs whether it's jobs, whether it's mental health, whether it is health programs. There should be money set aside specifically for older people.

Senator Pell. This is again where this act that I have proposed would be good because it applies for people who are 45 on up, and I would hope that the obvious merit of it, the fact that the return to the Government just in increased taxes on the increased wages that people would earn would bring the Congress around to support it. But these ideas take time, and I know you are aware of that.

Mrs. Tucker. We thank you for your efforts.

Senator Pell. Now, along the same line, I notice that you favor increased funds for administrative activities, that they have not been raised since 1979, I think it was.

Mrs. Tucker. Yes.

Senator Pell. How does that affect your ability to carry out the purposes of the Older Americans Act?

Mrs. Tucker. We are a minimum level State. That means that we get the minimum so that there is no increase in our administrative funds, and there has been no increase. If we do not have sufficient staff, if we do not have specifically trained staff, we cannot enforce the Older Americans Act.

Senator **Pell**. But isn't the reason why we are a minimum State is because our population is small the same as Vermont and North Dakota, other States with small populations?

Mrs. **Tucker**. That is true. And also our funds under the Older Americans Act are allocated on a formula basis, and we get less in other supportive funds too.

Senator **Pell**. I know the rough rule of thumb is always felt in the Senate that we should get half a percent, which is our population balance. Wouldn't we get half a percent under the Older Americans Act?

Mrs. **Tucker**. Yes, we do, Senator Pell.

Senator **Pell**. Thank you very much indeed.

Mrs. **Tucker**. You're welcome.

Senator **Pell**. Now, Miss Prior, I know you have got lots of questions and lots of thoughts and, as I said, you were a very stimulating influence on our staff in Washington. What do you think the best aspects are of the Older Americans Act as you have seen it in Rhode Island and what are the worst aspects of it? The best and the worst.

Miss. **Prior**. Oh, my. That's a real broad question.

Senator **Pell**. You better hold the microphone a little closer.

Miss **Prior**. The worst. That there is not enough activity to reach out to all of the people in the State of Rhode Island who certainly need to be contacted. I'm thinking of the time that I visited the Coventry Center and they were telling me about a gentleman who was living way off toward the Connecticut border and the Outreach Program was able to bring that person into the center and his life was improved. Now, there are many people like that, isolated people in Rhode Island, that I would like funds enough and workers enough, Outreach people, to get out and contact these people, see what's going on.

I guess we're frustrated a little bit by the fact that we have just so much money and just so many people to do the work and that the work is certainly out there.

Senator **Pell**. What do you see as the best aspect of the Older Americans Act?

Miss **Prior**. The best—well, we're recognized as a segment of population that needs special kinds of treatment. I think that's the best that I could say for that.

Senator **Pell**. I think those are two very good answers and very telling. On the one hand we need more outreach and more financial support, more support. On the other hand, the best thing is that it [illegible]gnizes the older citizens as a special segment of the population.

Miss **Prior**. I would say.

Senator **Pell**. The problem here, you say, is money; and just as those who are over 65 for example, feel social security benefits should be improved, those under 45 feel that the payments into the system should be decreased. It is a question of working out a balance here.

Miss **Prior**. That's what I meant by rethinking. We have to plan now for this large group that we must serve.

Senator **Pell**. We do because it will be overwhelmed in a few years——

Miss Prior. If we don't do it now.

Senator Pell [continuing]. By the increased number of citizens who are older than is the case now, the increased percentage.

Miss Prior. So we will have to educate the people in other segments of society that they will have to do some thinking for us.

Senator Pell. By the same token, with increased health, probably retirement age may go up a certain amount. People who are 65 today may have the same health or strength as somebody of 67, 10 years or 20 years from now; and I think this is also a possibility that has to be looked at, a difficult one.

Miss Prior. But there is a hurdle that we have to jump over, and the fact that there are many healthy people who would like to be employed——

Senator Pell. Right.

Miss Prior [continuing]. And have the strength and the vigor to be employed; but to compete with younger people in the job market is a pretty, pretty serious thing.

Senator Pell. Well, in politics I'll be doing just that for the next few years. Do you think that there are services that are needed in Rhode Island and that are not being provided now?

Miss Prior. Well, when I was asked to limit my presentation to 5 minutes, I selected the three needs that I thought were most important. And protective services for elderly people is my No. 1 problem. Efforts to pass a law in Rhode Island have been unsuccessful.

Senator Pell. That's true right across the country. We have the same problem about the need for the protection of older people.

Miss Prior. That has to come in the next few years because we will have more problems if we don't take care of a protective service act.

Senator Pell. If Senator Grassley or my colleagues have specific questions to offer you, we will send them to you for insertion in the record at a later date. I thank you both very, very much indeed for being with us.

Miss Prior. Thank you.

Senator Pell. Our next witnesses are Dr. Mary Mulvey, president of Rhode Island Council of Senior Citizens; and Murray Miller, State director of the American Association of Retired People. These two witnesses will focus on the Senior Community Service Employment Program, one of the programs in which the Older Americans Act provides multiple benefits to older Rhode Islanders. These Senior Community Service jobs are part-time jobs for low income, older workers; and the workers are placed in libraries and senior centers, police departments, and dozens of other places where they can contribute to the community while earning extra income and enriching their lives and those of their fellow citizens around them.

Now, speaking in behalf of the National Council of Senior Citizens will be Dr. Mary Mulvey who, as I said, is the president of Rhode Island Council of Senior Citizens and first vice president of the National Council. I can't think of another Rhode Islander who has done as much work over such a long period of time as has Mary Mulvey and who was instrumental in forming our State's first division of elderly affairs, the predecessor of the present department of elderly affairs. She worked closely with Congressman Fogarty and helped create the Older Americans Act of 1965 that we are now examining. She is one of the founding members of the National Council of Senior Citizens and one of the two founders that still serve on the board.

Dr. Mulvey, both on behalf of the State of Rhode Island and the United States, we thank you for being with us. Please proceed.

STATEMENT OF DR. MARY C. MULVEY, FIRST VICE PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Dr. **Mulvey**. Thank you, Senator, and Dave. I am glad you mentioned Congressman Fogarty because I don't think everybody in Rhode Island realizes that Congressman Fogarty was the author of the Older Americans Act which was passed back in 1965. And you assumed an important role in supporting passage of that, and we thank you for that and for all of your support for all programs for the elderly.

I am very happy to be here today to speak to the reauthorization of the Older Americans Act. With your permission, I would like to direct my remarks specifically to title V, the Senior Community Service Employment Program, one of the most successful employment programs ever established by Congress.

The National Council of Senior Citizens has sponsored title V projects around the country since its inception 16 years ago, 1968. And at the expense of modesty, I want to say that Providence, RI, had the first Senior Employment Program in the country under the sponsorship of my Providence Adult Education Department.

The program has grown over 16 years from a small $10 million project, demonstration project, to the present $319 million program. We helped write the first operating guidelines, and the program has grown now to eight national sponsors; and in the last 5 years the State offices on aging joined in the program.

Over the past 16 years, the title V program has enjoyed tremendous popularity in Washington and around the country. It has played a significant role in meeting local community needs, and that has never changed over the years.

We've always attempted to improve and streamline our program's operation. We are proud of the fact that while we have worked to improve the program, we have also sought ways to reduce the Federal administrative costs. Currently, the national cost, administrative cost rate, is less than 7 percent, although the law does allow up to 15 percent. Our savings in administrative costs have gone right back into participant wages. We have put 1,000 more to work with our small administrative cost than we would have had we adhered to the maximum.

Despite the program's demonstrated popularity and success, the Reagan administration has repeatedly chosen to single out title V as a program that must be terminated. You will recall that, only 3 months after endorsing a 3-year reauthorization in December 1981, the administration proposed eliminating title V altogether in the fiscal year 1983 budget.

This major assault and attempt by David Stockman and the Reagan administration to zero out title V and lay off over 54,000 older workers was defeated by the overwhelming bipartisan support title V had earned in Congress. We overrode the President's veto of a large supplemental appropriations bill. The only reason that that veto went through was that title V was included in that bill. And the Senior AIDES network was largely responsible for that veto.

Senator Pell, this brief history is important because the administration's past performance is prolog to this year's attack. The Reagan administration has learned the hard way that the title V jobs program is too popular and too important to be totally wiped out of the budget. Instead, they now propose that title V be shifted out of the Department of Labor and folded into the Administration on Aging. Under this proposal, the eight national sponsors who currently administer 80 percent of the program would be eliminated, and title V would be administered exclusively by the States and area agencies on aging. The motives of the administration and the results for thousands of older workers are essentially the same as the previous proposals.

Title V is first and foremost an employment program. The Older Americans Act itself states that the program is to provide "useful part-time opportunities in community service activities" targeted to those "unemployed low-income persons who are 55 years old or older and who have poor employment prospects."

There is no indication whatsoever that title V has not been effectively supervised by the Department of Labor. Since the program's inception, in fact, every independent study in the last 16 years has concluded that the program as it is currently being run is cost effective, well managed, and free of abuse. Why fix it if it ain't broke? Older workers under title V are considered workers first and older second at the Department of Labor.

But the administration would not merely shift over all administrative authority for title V out of its rightful home, the Department of Labor. To further undermine any hope for future success, they propose eliminating from participation the eight national contractors who currently administer nearly 80 percent of the program.

We suspect the proposal to eliminate national sponsors is motivated primarily by political considerations. NCSC, our national council, among other national aging groups sponsoring title V programs, has from time to time disagreed with the administration on questions affecting America's older population; for example, Social Security, medicare, medicaid, and budget cuts in programs for the poor. Advocacy on behalf of the elderly has been, since our first fight to establish medicare, the most important reason for the National Council of Senior Citizens to exist. Yet it seems that the price we are being asked to pay for our political differences is the dismantling of the title V program.

Older workers age 55 and over represent 23 percent of the Nation's long-term unemployed. We have not made a dent in the program, yet this modest employment program enrolls only 62,000 of an estimated 8 to 10 million eligible older Americans. Today more than ever older workers need title V. We should move more affirmatively to protect title V rather than to destroy it. The repeated attacks by this administration on the program have proven disruptive and harmful to the morale of the Senior AIDES network. Although some Federal programs may warrant administrative adjustments to bring about improvement, in the case of title V, we should not tamper with a time-tested and successful system which has consistently proven its worth.

Once again, we ask you and your committee, Senator Pell, and the entire Congress, to put an end to the administration's callous, calculated attempt to dismantle this important senior jobs program. We urge you to reauthorize title V as it is currently administered for a minimum of 3 years and at existing or higher funding levels. Thank you.

[The prepared statement of Dr. Mulvey follows:]

Statement by

Dr. Mary C. Mulvey, First Vice President
National Council of Senior Citizens

before the

Aging Subcommittee
Senate Labor and Human Resources Committee

January 17, 1984

Senator Pell, members of the Subcommittee, I am Dr. Mary Mulvey, First Vice President of the National Council of Senior Citizens. I am happy to appear before this Subcommittee today to talk about the reauthorization of the Older Americans Act. With your permission, I would like to direct my remarks specifically to Title V, the Senior Community Service Employment Program -- one of the most successful employment programs ever established by Congress.

The National Council of Senior Citizens has sponsored Title V projects around the country for sixteen years. As one of three original sponsors, we have seen this program grow from a $10 million demonstration project to a $319.45 million program. We helped write the first operating guidelines, which later became the first DOL program regulations. NCSC has seen five additional National Sponsors join the program, and in the last five years, the State Offices on Aging have joined as well.

Over the past 16 years, the Title V program has enjoyed tremendous popularity in Washington and around the country. The original concept, that low-income older workers have a vital role to play in meeting local community needs, has remained unchanged.

The services performed by older workers in nursing homes, day care centers and other community organizations account for the program's continuing popularity and support.

During our years of managing the Senior AIDES Program, we have always attempted to improve and streamline our program's operation. We have been able to respond very quickly over the years to priorities defined by the Department of Labor and Congress -- such as emphasis on environmental problems, weatherization assistance, crime prevention and, most recently, job placement assistance. We are proud of the fact that while we have worked to improve the program, we have also sought ways to reduce the federal administrative costs. Currently, our administrative cost rate is less than seven percent, although the law allows up to 15 percent. Our savings in administrative costs have gone right back into participant wages, enabling 1000 additional older workers to be employed above our DOL required levels.

Yet, despite the program's demonstrated popularity and success, the Reagan Administration has repeatedly chosen to single out Title V as a program that must be terminated. You will recall that, only three months after endorsing a three-year reauthorization in December 1981, the Administration proposed eliminating Title V altogether in the FY 1983 budget.

This major assault -- an attempt by David Stockman and the Reagan Administration to 'zero-out' Title V and lay off over 54,000 older workers -- was clearly defeated by the overwhelming bi-partisan support Title V had earned in the Congress. The eventual override of the President's veto of a large supplemental appropriations bill was attributed to objections that funding for

Title V was included in that bill. Despite the fact that funds for Title V were only a small fraction of that Supplemental Appropriations bill, floor statement after floor statement reflected Congressional concern over the continuation of this program. Congressman Silvio Conte, ranking minority member of the House Appropriations Committee, had this to say:

> The single largest issue in the debate over the veto of the Supplemental Appropriations bill is whether a jobs program that keeps 54,200 older Americans out of poverty and provides valuable services to the elderly and to all of us will be continued... The President has made clear his intention to terminate this program as of September 30, and the older workers are already receiving notices of their impending termination.

Senator Pell, this brief history is important because the Administration's past performance is prologue to this year's attack. The Reagan Administration has learned the hard way that the Title V jobs program is too popular and too important to be totally 'wiped-out' of the budget. Instead, they would now propose that Title V be shifted out of the Department of Labor and folded into the Administration on Aging. Under this proposal, the eight national sponsors who currently administer 78 percent of the program would be eliminated, and Title V would be administered exclusively by the states and Area Agencies on Aging. Although this proposal may appear to some to be a minor administrative adjustment, the motives of Administration strategists and the results for thousands of older workers are essentially the same as earlier proposals.

Title V is first and foremost an employment program. The Older Americans Act itself states that the program is to provide "useful part-time opportunities in community service activities" targeted to those "unemployed low-income persons who are 55 years old or older and who have poor employment prospects." There is no agency of the Federal government that has more expertise in carrying out the objectives of this program than the Department of Labor. Nor is there any indication that Title V has not been effectively supervised by DOL since the program's inception. In fact, every independent study in the last sixteen years has concluded that the program, as it is currently being run, is cost-effective, well managed and free of abuse. Why tamper with a formula that has been proven successful? Older workers under Title V are considered workers first and older second at the Department of Labor. That is as it should be in an employment program.

But the Administration would not merely shift overall administrative authority for Title V out of its rightful home, the Department of Labor. To further undermine any hope for future success, they propose eliminating from participation the eight national contractors who currently administer nearly 80 percent of the Title V funds. These sponsoring organizations such as the National Council of Senior Citizens not only have the most expertise in effectively operating the senior jobs program, but have been largely responsible for its survival and expansion. Again we ask the Administration, why attempt to fix the program if it is not broken?

We suspect the proposal to eliminate National sponsors is motivated primarily by political considerations. NCSC, among other national aging groups sponsoring Title V Programs, has from time to time disagreed with the Administration on questions affecting

America's older population. Certainly we have called to the attention of our members the Administration's past position on Social Security, Medicare and budget cuts in programs for the poor. Advocacy on behalf of the elderly has been, since our first fight to establish Medicare, the most important reason for the National Council of Senior Citizens to exist. Yet, it seems that the price we are being asked to pay for our political differences is the dismantling of the Title V Program.

Currently, older workers age 55 and over represent 23 percent of the nation's long-term unemployed. The Title V Senior Community Service Employment Program represents the only major government response to the needs of older workers. Yet, this modest employment program enrolls only 62,000 of an estimated 8 to 10 million eligible older Americans. Today, more than ever, older workers need Title V. Recognizing the tremendous contributions that these proud, older Americans are making to our communities, we should move more affirmatively to protect Title V rather than destroying it. The repeated attacks by this Administration on the program have proven disruptive and harmful to the morale in the Senior Aides network. Although some Federal programs may warrant administrative adjustments to bring about improvement, in the case of Title V, we should not tamper with a time-tested and successful system which has consistently proven its worth.

Once again we ask the members of this subcommittee and the entire Congress to put an end to the Administration's callous, calculated attempt to dismantle this important senior jobs program. We urge you to reauthorize Title V as it is currently administered for a minimum of three years and at existing or higher funding levels.

Thank you.

Senator **Pell.** Thank you very much, Dr. Mulvey. Now, our next witness is Murray Miller, State director of the American Association of Retired Persons and formerly served as chairman of the American Association of Retired Persons. He has been a member of the—in prior years when Mr. Miller was used to getting paid for his work, he served in the Social Security Administration in their Survey Branch. Would you proceed, Mr. Miller.

STATEMENT OF MURRAY MILLER, STATE DIRECTOR, RHODE ISLAND, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. **Miller.** Thank you very much, Senator Pell, David.

Members of the Subcommittee on Aging, my name, as indicated, is Murray Miller, and I am State director for the Rhode Island American Association of Retired Persons. In the State of Rhode Island, we represent over 77,000 members. Nationally, over 15 million members. The largest organization of its type in the world.

I realize your time is limited, Senator. Consequently, I shall try to keep my remarks brief. I have been asked by the association to focus on title V, Senior Community Service Employment Program.

AARP is basically expressing three principles for reauthorization of the Senior Community Service Employment Program.

CONTINUE TITLE V IN THE DEPARTMENT OF LABOR

First, title V should remain in the Department of Labor as a separate categorical program. The administration's proposal to replace the Senior Community Service Employment Program with a new employment opportunities program—community service employment and a new self-employment component—under the direction of the Administration on Aging should be rejected.

Title V has been an extraordinarily effective program by any standard one would choose to use. The program has consistently received high marks by independent evaluators. Administrative expenses have been kept at a rockbottom level so that more funds can go directly to older workers.

The administration's proposed employment opportunities program is a seriously flawed measure. The proposed $277.1 million authorization is $52.35 million below the current $319.45 million funding level for the 1983-84 program year. This would force many low income, older workers to lose their jobs.

In addition, the potential $55.4 million set-aside—up to 20 percent of the $277.1 million authorization—for self-employment would fundamentally alter the program. The harsh reality is that the switchover from the Senior Community Service Employment Program to the New Employment Opportunities Program would cause great disruption for title V enrollees, administrators, and the communities now served.

As a practical matter, the Administration on Aging should not be burdened with another major responsibility—administering an employment program—especially when the agency is already thinly staffed to carry out its present statutory mandates. AOA is charged with administering supportive services and nutrition programs under the Older Americans Act. This agency simply does not have the necessary expertise to administer an employment or self-employment program. Quite to the contrary, AOA asked to be relieved of the responsibility for administering the title X, Emergency Jobs Program when it was given this task briefly in the mid-1970's.

AARP strongly believes that the Department of Labor should administer an employment program because it has primary responsibility for work and training activities. Congress gave careful consideration to the proper placement of a senior jobs program when it created the senior jobs program. After much deliberation, a decision was made with virtually unanimous support to have the Department of Labor administer the National Senior Service Corps, and not AOA. There is an old saying, as previously indicated, that people should not try to fix something when it is not broken. This certainly applies to the administration of title V by the Department of Labor.

Finally, supporters of shifting title V to AOA have a twofold burden to make their case. First, they must show that the program will operate more effectively and efficiently at AOA without causing great disruption. Second, they must show how this will occur. This case has simply not been made. For these reasons, AARP reaffirms its support for retention of title V in the Department of Labor. The Gray-Panetta-Conte resolution—House Concurrent Resolution 43—would put the Congress on record in keeping the Senior Community Service Employment Program at Labor. Over 150 Members of the House have sponsored this measure.

A 3-YEAR REAUTHORIZATION

Second, AARP favors at least a 3-year extension of title V. The value and worth of the Senior Community Service Employment Program have been amply demonstrated over the years. A program as successful and effective as title V deserves to be continued for at least 3 years. This will provide greater continuity for the Senior Community Service Employment Program as well as prevent disruptive start and stops.

Congress has traditionally approved 3-year extensions of title V. This helps program administrators in planning their activities with adequate lead time. At the same time, a 3-year extension enables the Congress to review the program periodically. Therefore, we urge again that title V be extended for at least 3 years.

INCREASED AUTHORIZATION LEVELS

Third, the authorization levels for the Senior Community Service Employment Program should be fixed at higher levels to take into account higher costs and permit some expansion to enable more low income, older persons to participate.

Title V costs have increased in recent years and will rise in the years ahead because:

Worker compensation costs have risen sharply in recent years.

The Federal unemployment tax rate increased in January 1983 from 3.4 percent to 3.5 percent and the taxable wage base rose from $6,000 to $7,000.

Social Security taxes have risen. Payroll taxes will increase significantly in the years ahead because of the 1983 Social Security amendments. In fiscal year 1984, there will be two Social Security tax hikes, from 6.7 percent to 7 percent in January 1984 and then to 7.05 percent in January 1985.

An estimated 100,000 persons 55 or older will participate in the Senior Community Service Employment Program during the 1983-84 program year. The need, though, is greater because unemployment has ranged from 741,000 to 825,000 throughout 1983. Many unemployed, low income, older Americans are ready, willing, and able to work. All they need is a chance. Title V can provide them with that opportunity, as well as a new lease on life.

Thank you, Senator Pell, for the opportunity to appear at this hearing. The American Association of Retired Persons wishes to commend you for beginning your hearing at this early date to provide the necessary information for reaching sound decisions on the future directions of the Senior Community Service Employment Program.

[The prepared statement of Mr. Miller follows:]

STATEMENT BY

MURRAY MILLER

STATE DIRECTOR, RHODE ISLAND
AMERICAN ASSOCIATION OF RETIRED PERSONS .

Thank you very much Senator Pell and Members of the Subcommittee on Aging. My name is Murray Miller, and I am state director for the Rhode Island American Association of Retired Persons. I realize that your time is limited. Consequently, I shall keep my remarks brief.

I have been asked to focus on the Title V Senior Community Service Employment Program.

AARP is basically advocating three principles for reauthorization of the Senior Community Service Employment Program.

A. Continue Title V in the Department of Labor

First, Title V should remain in the Department of Labor as a separate categorical program. The Administration's proposal to replace the Senior Community Service Employment Program with a new employment opportunities program (community service employment and a new self-employment component) under the direction of the Administration on Aging should be rejected.

Title V has been an extraordinarily effective program by any standard one would choose to use. The program has consistently received high marks by independent evaluators. Administrative expenses have been kept at a rock bottom level so that more funds can go directly to older workers.

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In addition, the potential $55.4 million set aside (up to 20% of the $277.1 million authorization) for self-employment would fundamentally alter the program. The harsh reality is that the switchover from the Senior Community Service Employment Program to the new employment opportunities program would cause great disruption for Title V enrollees, administrators, and the communities now served.

As a practical matter, the Administration on Aging should not be burdened with another major responsibility -- administering an employment program -- especially when the agency is already thinly staffed to carry out its present statutory mandates. AoA is charged with administering supportive services and nutrition programs under the Older Americans Act. This agency simply does not have the necessary expertise to administer an employment or self-employment program. Quite to the contrary, AoA asked to be relieved of the responsibility for administering the Title X emergency jobs program when it was given this task briefly in the mid-1970's.

AARP strongly believes that the Department of Labor should administer an employment program because it has primary responsibility for work and training activities. Congress gave careful consideration to the proper placement of a senior jobs program when it created the senior jobs program. After much deliberation, a decision was made, with virtually unanimous support, to have the Department of Labor administer the national senior service corps, and not AoA. There is an old saying that people should not try to fix something when it is not broken. This certainly applies to the administration of Title V by the Department of Labor.

Finally, supporters of shifting Title V to AoA have a twofold burden to make their case. First, they must show that the program will operate more effectively and efficiently at AoA without causing great disruption. Second, they must show how this will occur. This case has simply not been made. For these reasons, AARP reaffirms its support for retention of Title V in the Department of Labor. The Gray-Panetta-Conte resolution -- House Concurrent Resolution 43 -- would put the Congress on record in keeping the Senior Community Service Employment Program at Labor. Over 150 members of the House have sponsored this measure.

B. Three-Year Reauthorization

Second, AARP favors at least a three-year extension of Title V. The value and worth of the Senior Community Service Employment Program have been amply demonstrated over the years. A program as successful and effective as Title V deserves to be continued for at least three years. This will provide greater continuity for the Senior Community Service Employment Program as well as prevent disruptive start and stops.

Congress has traditionally approved three-year extensions of Title V. This helps program administrators in planning their activities with adequate lead time. At the same time, a three-year extension enables the Congress to review the program periodically. Therefore, we urge again that Title V be extended for at least three years.

C. Increased Authorization Levels

Third, the authorization levels for the Senior Community Service Employment Program should be fixed at higher levels to take into account higher costs and permit some expansion to enable more low-income older persons to participate.

Title V costs have increased in recent years and will rise in the years ahead because:

-- Worker compensation costs have risen sharply in recent years.

-- The Federal unemployment tax rate increased in January 1983 from 3.4% to 3.5% and the taxable wage base rose from $6,000 to $7,000.

-- Social Security taxes have risen. Payroll taxes will increase significantly in the years ahead because of the 1983 Social Security Amendments. In fiscal year 1984, there will be two Social Security tax hikes, from 6.7% to 7.0% in January 1984 and then to 7.05% in January 1985.

An estimated 100,000 persons 55 or older will participate in the Senior Community Service Employment Program during the 1983-84 program year. The need, though, is greater because unemployment has ranged from 741,000 to 825,000 throughout 1983. Many unemployed low-income older Americans are ready, willing, and able to work. All they need is a chance. Title V can provide them with that opportunity, as well as a new lease on life.

Thank you for the opportunity to appear at this hearing. AARP wants to commend you for beginning your hearing at this early date to provide the necessary information for reaching sound decisions on the future directions of the Senior Community Service Employment Program.

Senator PELL. Actually, the purpose of title V is very similar to my Older Americans Vocational Education Act. The putting back into the productive stream of workers those who have lost their jobs through no fault of their own through structural unemployment. If my bill is not passed, which is not too likely, though I keep pressing it, in the near future, I am sure eventually it will be. You suggest there should be higher authorizations for title V. I think both of you feel that way.

Mr. MILLER. Absolutely.

Senator PELL. Do you have any suggestions as to where that money should come from?

Dr. MULVEY. From Congress. From Congress. From the Department of Labor as it is now. But actually it has been proven many times that the investment, this is a cost-effective program. The investment that is made returns more than the investment to the community, to the workers themselves financially, to say nothing of the psychological effects. But it really is cost effective. It isn't an all-out appropriation. It comes back.

Senator PELL. I would agree with you strongly. This is an argument that the advocates should make more often. This is a program, instead of putting an older person who lost his job on the dust pile, it puts him back in the earning stream; and I think it is cost effective and does pay for itself in the end. How many title V community jobs are administered in Rhode Island?

Dr. MULVEY. Do you want to answer that one?

Mr. MILLER. I would defer that question to our Senior Community Service Employment Program director, Mr. Frank Centazzo, or perhaps Mrs. Tucker may have the available figures.

Dr. MULVEY. I know. You mean how many programs?

Senator PELL. How many employees in Rhode Island?

Dr. MULVEY. Around 350. In round numbers, workers, yes.

Senator PELL. Could you give us a couple of specific examples of the type of jobs that seniors are placed in through this program?

Dr. MULVEY. Yes. Every place. I will give you a little laundry list, and then Murray can add to it. In hospitals, in schools——

Senator PELL. No. The actual jobs. Not just in hospitals. What do they do?

Dr. MULVEY. Oh, they work as aides in hospitals, they work—they work in the nutrition sites that are funded by AOA. They work in the kitchen, they take reservations, they work at the tables, they do outreach work for agencies, and that kind of thing. There's nothing that they don't do. Nothing.

Senator PELL. I am interested also in what jobs in private industry seniors have done.

Dr. MULVEY. They have to work in nonprofit agencies. They cannot work in private profitmaking agencies. Now, one of the goals is to place them into private industry after they have acquired the skills through training and so forth and they are ready. There is a part of the—a small amount of money is set aside to train the senior aides in private industry. It is called extra. But the private industry will train them, but they must make a commitment beforehand that they must hire them.

Now, the national council does have some of those programs going in New Bedford, we have five of those programs going. The senior aides have been trained as insurance clerks by the insurance association, and the insurance companies have already picked them up. They are trained in home health care work by profitmaking home health care agencies. But there is that commitment that the agency must hire them afterwards.

Now, it is just a small amount of money, I think it is 3 percent of the whole appropriation, the national council has some going out West and Midwest, but I do know the ones around New England and they are working out nicely.

Senator **Pell**. What would be an example in Rhode Island of a specific industry job that one of these individuals has moved into?

Dr. **Mulvey**. Well, now we have Rhode Islanders here, yes. I'll speak to the newest Providence project under the sponsorship of Self-Help. Self-Help has picked up three of those senior aides already, and the program only started in July. But the senior aides worked out so well that Self-Help, as soon as the opportunity arose for a job slot, then Self-Help gave the senior aide top priority. So they have picked up three. In Providence about four or five have been picked up recently out there in Silver Lake, that agency has picked up one.

Now, the AARP, really, their philosophy is somewhat different from the philosophy of the national council. Now, our national council places high priority in providing community services. The AARP is a little more oriented toward training and placement. So you probably have a big laundry list of places where your AARP aides have been placed. We call it unsubsidized employment.

Mr. **Miller**. Right. There are many of them that have been placed in the library type of work. They have also worked as aides in hospitals, clerical work, part time, of course, bookkeeping type of functions, and many others in that category.

Senator **Pell**. What I would ask, and I would ask Mrs. Tucker if she could help us in this, if she could submit later on for the record a laundry list of jobs in Rhode Island not necessarily in the public domain but in the private domain, and I would include hospitals in that, of specific jobs that these people have been placed in because I think that would add to our ammunition in Washington in trying to get the bill reauthorized. I guess Mrs. Tucker would have the best access to those figures, and if she would, she would consult with Dr. Mulvey and Mr. Miller.

Now, another question I would like to raise, and that is in behalf of the majority and Senator Grassley, is what is your view with regard to the reduction of the administrative cost of title V and reauthorization because, as you know, we are always trying to reduce administrative costs if we can make sure the money goes directly to the people. What would be your reaction to that?

Mr. **Miller**. Senator Pell, in answer to that I would say if every program sponsored and authorized by the Government of the United States has been administered as well as the title V program, I think we'd be in excellent shape all across the country.

Dr. **Mulvey**. The law allows up to 15 percent for administrative costs for such a program. That's not exorbitant. But I want to stress that our National Council of Senior Citizens has kept its administrative costs to under 7 percent.

Senator **Pell**. But then in essence you believe there should not be any reduction in administrative costs of title V?

Mr. **Miller**. Absolutely not, Senator.

Senator **Pell**. Right. Dr. Mulvey, going back for a second to the percentage of workers or the workers who are placed in private unsubsidized jobs, would you say roughly that it's half and half or one-quarter, three-quarters? In Rhode Island I am talking about.

Dr. **Mulvey**. Well, in Rhode Island I think that we're going to—the Department of Labor uses a rate of 15 percent, that 15 percent should be the goal of placement over a funding period. Now, I'm sure that the East Providence project is well on its way. They will probably have their 15 percent in another month. Providence is a little slower because, you know, Providence is very poor; but we hope that Providence will meet its 15 percent. Overall, you don't—each community doesn't have to—I mean each project doesn't have to meet 15 percent. It is just the average, the national average should be 15 percent of placements.

Senator **Pell**. And when you testify to this, Dr. Mulvey, you bring a wealth of experience. You have been working on the senior community service employment job area for how many years?

Dr. **Mulvey**. Well, I ran one myself for 11 years myself.

Senator **Pell**. That was how many years ago?

Dr. **Mulvey**. Now I am supervising the projects in this area. I visit the projects that are operating under the national council.

Senator **Pell**. So it's been about 15 years that you have been working in this?

Dr. **Mulvey**. More than that.

Senator **Pell**. A little reluctancy to say how long.

Dr. **Mulvey**. Nearer 20.

Senator **Pell**. I thank you both very much indeed. Dr. Mulvey is a dear old friend. Mr. Miller, very glad that you were here.

Mr. **Miller**. Thank you, Senator, and thank you, David.

Senator **Pell**. Without objection, we will have inserted in the record at this point a batch of letters in connection with title V, and they will be made part of the official record.

[The following was received for the record:]

January 1984

Dear Senator Pell:

As a Senior Citizen, I strongly urge you, as a Senator, to help in the reauthorization of the Older Americans Act and to see that it remains under the jurisdiction of the Department of Labor.

Thank you.

Name Marie C. Wright

Address [illegible]
[illegible] 02915

The Subcommittee on Aging received 108 petitions that were exactly the same or similar to the above petition. Due to expense, the Subcommittee was unable to publish all of these petitions. They are on file at the Subcommittee office and available for public perusal.

Senator Pell. Our next witnesses are Sr. Ruth Crawley, director of the Fruit Hill Day Center for the Elderly; and Dr. Sidney Katz, director of the Southeast New England Long-Term Care Gerontology Center at Brown; and Jane MacKenzie of the Visiting Nurse Service.

As you can all see, there are a lot of letters concerning title V that are coming up here.

This next group of witnesses will discuss the long-term care under the Older Americans Act. This is a very important topic because care of the frail elderly will dominate an increasing amount of our attention and resources in the coming decades. Several months ago the Census Bureau estimated that the number of Americans 65 years and older will double, will double, by the year 2030. That's a growth of over 25 million older Americans in 1980 to more than 51 million in 2030. The growth of those 85 and older, the segment of our population most in need of long-term care, will be staggering. That population will grow fivefold by that year, growing from 1 percent of our population in 1982 to 5 percent in 2015. Increasing numbers of the very elderly will cause increasing strain on our health care system, particularly more medicare and medicaid. We need to anticipate these strains and control them before they control us. I believe that the Older Americans Act has a leadership role to play in this regard; and to support the social services the act provides together with the appropriate medical attention can help at home together with these communities. We have much to learn, and the next three witnesses are particularly well qualified to speak on this subject.

Sr. Ruth Crawley is the director of the Fruit Hill Day Center for the Elderly. Sr. Ruth.

STATEMENT OF SR. RUTH CRAWLEY, F.M.M., DIRECTOR OF FRUIT HILL DAY CENTER FOR THE ELDERLY

Sr. Crawley. Thank you, Senator Pell, and David.

I address you and all the members of the committee, Subcommittee on Aging. The spectacular growth of adult day care, referred to as elderly day care also, in this Nation during the past decade gives credence to the fact that indeed elderly day care is an idea whose time has come. According to a study submitted by Drs. Spence and Clark at the University of Rhode Island in November 1983, "Between 1980 and 2030, the U.S. population will double, and the population over the age of 85, the group most likely to require long-term care and at the highest risk for institutionalization, will almost triple." We attest to this statement today at the Fruit Hill Day Care Center because we now have 33 percent of our people over 85. Since this is the population that we service in the elderly day care centers, we believe that it is our duty to encourage government officials to consider the pressing need for effective funding for the present providers as well as future program development.

Title III of the Older Americans Act provides funds for home care and community-based social services. For this grant which originally initiated our programs, we are grateful. But as grateful as we are for the Older Americans Act, the wording of the provisions, it seems to us, well, the wording of the provisions need to emphasize the medical aspects to us rather than stressing only the social services. Present day funding is strikingly inadequate for the medical services provided by elderly day care facilities.

I will give you one case today, a female, age 70. Her problems consist of uncontrolled diabetes, coronary heart disease with angina, arteriosclerotic heart disease, peripheral neuritis, stasis edema of both legs, mild chronic brain syndrome, neurogenic bladder, arthritis, hearing loss, vision loss, poor circulation, difficult ambulation, obesity, poor memory, and depression. This case represents the multiple problems that face the aging, not only this one person, but all the aging, and the complex treatment which is necessary for quality health care which is tremendous.

In the Congressional Record of February 3, 1983, Senator Pell, quoting from an article in the New York Times magazine by Didi Moore on America's neglected elderly.

> Of the 26 million Americans over the age of 65, nearly 40 percent suffer from some chronic physical or mental handicap. In addition, as a result of major social and economic changes, families, the traditional support system, are now in less of a position than ever before to take on the extended care of the elderly relatives.

Because of this shift in care from independent services to qualified licensed health care facilities; namely elderly day care centers, we view it from our experience in the continuum of long-term care.

The bigest challenge over the next few years will be in establishing elderly day care as a third-party reimbursable service, and we add here also title XIX should be explored again for possible inclusion of additional funds as well as other types of reimbursement to be explored such as insurance companies, veterans association, churches, community, philanthropic or private sources. At the present time, we are happy and fortunate to receive State support from the department of elderly affairs for elderly day care services, and we strongly hope that it will continue for the need of our elderly people who live on limited incomes but who do not qualify for categorical assistance.

We have a tremendous task to face, and our responsibilities get greater every day. But our philosophy evolves from our belief in the value and dignity of every human being, even when the task seems most helpless. We believe in supporting our participants in a warm, friendly atmosphere and helping them to maintain a life style befitting wellness and to prevent institutionalization as long as possible. Elderly day care centers have progressed sufficiently to justify national recognition for its value as a component in the long-term health care system and a viable one in its own right.

I thank you, Senator Pell, for your support for elderly day care centers, a minority group, but a very important one to humanity, and for the spectacular growth in the future.

[The prepared statement of Sr. Crawley follows:]

Fruit Hill Day Center for Elderly

399 Fruit Hill Avenue North Providence, R. I. 02911

Telephone: (401) 353-5805

January 17, 1984

From: Sr. Ruth Crawley, F.M.M.
Director

To: U.S. Senator Claiborne Pell

The spectacular growth of Adult Day Care in this nation during the past decade gives credence to the fact that indeed Elderly Day Care is an idea whose time has come. According to a study submitted by Drs. Spence and Clark at the University of Rhode Island, November 1983, "Between 1980 and 2030, the elderly United States population will double, and the population over the age of 85, the group most likely to require long term care and at the highest risk for institutionalization -- will almost triple." Since this is the population that we service in the Elderly Day Care Centers, we believe that it is our duty to encourage government officials to consider the pressing need for effective funding for the present providers as well as for future program development.

TITLE III of the Older Americans Act provides funds for Home Care and Community-based social services. For this grant which originally initiated our programs, we are grateful. But as grateful as we are for the Older Americans Act, the wording of the provisions needs to emphasize the medical aspects rather than stressing only the social services. Present day funding is strikingly inadequate for the medical services provided by Elderly Day Care facilities. Case in point: Participant A - age 70. (See page 2)

Problems

Diabetes Mellitus (on Insulin)
Coronary Heart Disease with Angina
Arterio Sclerotic Heart Disease
Peripheral Neuritis
Stasis Edema of both legs
Mild chronic brain syndrome
Neurogenic bladder
Arthritis
Hearing loss
Vision loss
Poor Circulation
Difficult ambulation
Obesity
Poor Memory
Depression

Care Plan

Health maintenance
Restorative care
Nursing care and treatment
Diabetic training
Good hygiene
Nourishing but controlled diet for Diabetes and loss of weight
Limited exercise
Activities as tolerated (Occupational Therapy)
Encourage independence
Social involvement
Assistance with activities of daily living when required
Mental Health Therapy
Speech Therapy

This case represents the multiple problems that face the aging and the complex treatment necessary for quality health care.

In the Congressional Record of February 3, 1983, Senator Pell quoting from an article in the New Your Times Magazine by Didi Moore on AMERICA'S NEGLECTED ELDERLY "Of the 26 million Americans over the age of 65, nearly 40 percent suffer from some chronic physical or mental handicap. In addition, as a result of major social and economic changes, families, the traditional support system, are now in less of a position than ever before to take on the extended care of the elderly relatives." Because of this shift in care from independent services to qualified licensed health care facilities, namely Elderly Day Care Centers, we view it from our experience in the continuum of Long Term Care.

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The biggest challenge over the next few years will be in establishing Elderly Day Care as a 3rd party reimbursable service. Furthermore, Title XIX should be explored again for possible inclusion of additional funds as well as other types of reimbursement such as insurance companies, Veterans Association, churches, community, philanthropic or private sources. At present, we are happy and fortunate to receive State support for Elderly Day Care services and strongly hope that it will continue for the need of our elderly people who live on limited incomes but who do not qualify for categorical assistance.

We have a tremendous task to face, and our responsibilites are greater, but our philosophy evolves from our belief in the value and dignity of every human being, even when the task seems most helpless. We believe in supporting our participants in a warm, friendly atmosphere and helping them to maintain a life-style befitting WELLNESS and to prevent institutionalization as long as possible. Elderly Day Care Centers have progressed sufficiently to justify National recognition for its value as a component in the Long Term Health Care system and a viable one in its own right.

Senator **Pell**. Thank you very much. Now, Dr. Katz.

STATEMENT OF SIDNEY KATZ, M.D., DIRECTOR, SOUTHEAST NEW ENGLAND LONG-TERM CARE GERONTOLOGY CENTER, BROWN UNIVERSITY, PROVIDENCE, RI

Dr. **Katz**. I would like to build on some of the remarks that have been made.

Senator **Pell**. May I add that your statement will be inserted in full in the record that we have.

Dr. **Katz**. Thank you.

Senator **Pell**. Thank you.

Dr. **Katz**. I thank you both, Senator Pell and David, whom I have had contact with. You have heard of this emerging problem of the aging population, and we're part of it, all of us, including myself. You heard that long list that Sr. Crawley gave of conditions of one person. You may not be aware that in various studies every person, the average number of chronic conditions, is 3 to 6 after the age of 65. And the risk is not so much one of the disease itself, but the risk is of losing one's independence in function. When we sit with a group of well elderly, most of you would be classified in that category, and we ask you what you want, most of our elderly will say, "We want to maintain our function as long as possible. We would like to stay home as long as possible and not in institutions." That's been very common.

The problem that comes up is that when these conditions lead to disability or loss of function and when long-term care is needed, the cost of that care is very high. We have seen, for example, that the cost of nursing home care has doubled every 4 or 5 years over the last 8 years and is likely to continue at that rate. It's at $16 billion a year and higher right now. Other aspects of long-term care cost even more. The need then, as far as we are concerned, are values set, to slow deterioration, avoid it as long as possible, slow it as much as possible, and help people to live out this long life that is now being lengthened, to live it out in a more functionally self-caring capacity.

Now, I would go back to a word that Anna Tucker introduced. She talked of a partnership. In fact, we talk of coordinated care in long-term care as a basic requirement, but we are also talking of a partnership but in the care arena. I do think we need a partnership of pulling together social services, support services, health services, medical services. And, Senator Pell, I don't think we've yet achieved that, unfortunately.

I think, in fact, that there is no process for melding and coordinating that care in our Nation. In fact, the current policies, and if they would be measured by the amount of expenditures that are reflected in policies, go in the opposite direction. We are favoring large expenditures for separate medical health and social services. Separateness. We are favoring through reimbursement separation of reimbursement. We are favoring separate ways of delivering those services, and we are favoring separate leaderships.

Now, I think that Congress did recognize this, and you among the congressional people back when the Older Americans Act was passed because the words of intent did say that there were two kinds of tools that the Older Americans Act would serve as a tool in two senses. One, to enable the delivery of services that were not available, especially in the social arenas; and the other was to be an advocate for bringing together the broad aging network in the Federal Government at the State level and at the local level. That has been very difficult to achieve to this point.

Now, in part the broad network that I'm talking about does include people who are also outside of the Older Americans Act. There are many agencies and groups, we heard of some today, who are interested in the aged and whose work should be coordinated and integrated fully in terms of partnerships to achieve the best for the older population. And as funds have been drying up in a sense or less effective even by virtue of—even when they seem to hold the line and inflation gets ahead of us, one of the things that happens is even the Older Americans Act structure has favored its own structure. We have found ourselves being, trying to find ways to broaden our influence on the broader network.

I speak today for one segment which is the university long-term care gerontology centers of which, as you indicated, I direct one. These were designed to help develop new ways of pulling together services. That is a university kind of capability. These were organizations that were designed to help in technical assistance around issues of partnership to provide assistance to local, State, and Federal Government. These were and these are, I should be using the present tense, these are organizations which are training new manpower for this future.

Only as short ago as 2 years ago there were 50 qualified new geriatric physicians trained in this country. The whole of the country. And there were very few nurse practitioner programs in existing programs where nurses are trained. We are just getting a start at making a dent in that need. Until we have some of those things, I doubt that we are going to meet fully what Sr. Crawley indicated.

Now, as examples of some of the things that we have done as a gerontology center, I will speak of a few, I will just list them because of the time, at Brown, but this has been going on in the 10 gerontology centers around the country. We have an organization through which we interrelate with each other and can deliver both information about what goes on at other places and the knowledge to our own constituencies. But we have worked in our gerontology center as the evaluators for the National Hospice Program which has an impact on legislation and on directions for a new model of services. We have been helping to train geriatric nurse practitioners. And beyond the point of training them, we have been trying to work out methods of introducing those practitioners into communities. We do serve at this point in the—on the Rhode Island Governor's Commission which is looking at the relationships between long-term care hospitals and acute hospitals, trying to interrelate and coordinate them better. A very noteworthy and stimulating, exciting kind of event that we have been party to is that we have now for the first time been able to provide information on how long we are likely to live an active life.

Let me give you one example of such information. After age 65, between age 65 and 70, our life expectancy is about 18 to 20 years. Our active life expectancy, according to this new information, is about 10 years. Which means that we have a chance of being dependent and requiring service for about 10 years, the difference. We know that those who are economically disadvantaged have a shorter active life expectancy at every age. At age 65 to 70, this is 2 years shorter than for those people who are not economically disadvantaged. We have a chance now to try to target some of our efforts to promote the well-being of people who are in those positions and lose their active life and, if you will, for the first time to address rather than living a long life, which all of us want, but a better life, a quality life.

In the reauthorization, we have had considerable difficulty as gerontology centers. I'll illustrate our gerontology center problem, but this is magnified around the country. We originally were designed to be the Southeastern New England Long-Term Gerontology Center covering parts of three States, not covering Boston. And by now we're being asked with the same resources to cover six States, all of New England. So we would like to see—and there has been a trend to move the centers out of the bill and out of the discretionary portion of the bill over the last 1 year that we have successfully fought. But we need stability.

We would like to be recognized in the wording of the bill, have the Nation's 10 regions each include at least one longterm care gerontology center linked and coordinated with each other, recognized in wording within the bill, strengthened, if possible, but even stabilizing our position would make us more efficient in our products.

[The prepared statement of Dr. Katz follows:]

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Southeastern New England Long Term Care Gerontology Center
Box G Brown University Providence, Rhode Island 02912 Tel. 401 863-3211

Addressing the Geriatric Imperative

(Southeastern New England Long-Term Care Gerontology Center)

Testimony by Sidney Katz, M.D.

Long-term care is now a national priority. Compelling demographics, fiscal and human factors have made it so. In response to this priority, university-based and community-oriented Long-Term Care Gerontology Centers have been established to initiate fundamental changes in the existing expensive, uncoordinated and fragmented system of long-term care. By federal mandate, these changes must address the unique and constantly growing need among the elderly in a framework of both limited resources and human values.

In pursuit of this mission, the Administration on Aging funded five Long-Term Care Centers in 1980, four in 1981, and two more in 1983.

These operational centers are responsible for:

- Educating new practitioners and providing on-going training and "hands on" learning experiences for those already involved in the long-term care system.
- Developing innovative, cost-efficient and replicable service models which facilitate the independence of elderly and emphasize a continuum of community based, alternative care services. This includes innovative models of health promotion and disease prevention.
- Stimulating and conducting basic and applied research in geriatric/gerontology and long-term care.
- Providing technical assistance to state and local governments, professional organizations and service providers that plan and deliver services to the elderly.

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- o Identifying policy issues and developing options and priorities in long-term care for national, state and local implementation.
- o Disseminating information to professionals and to the public on progress and accomplishments made in these areas.

The Long-Term Care Gerontology Centers represent a unique national resource in that they attempt to resolve problems of long-term care by marshalling the combined resources and viewpoints of academics, policy makers, researchers, planners and community-based providers. It is the only nationwide program with a multidisciplinary and multiorganizational approach that encourages joint problem-solving in the area of long-term care. By bringing academics and medical practitioners into what traditionally has been a planner/provider network, an expanded knowledge base is made available for use in developing education, technical assistance and service delivery systems.

The national geriatric imperative is a result of the rapidly increasing numbers of older Americans, their special needs, and the continued absence of a rational national policy to improve the quality of their lives. In this regard, about 85 percent of older Americans suffer one or more chronic conditions, and more than 42 per cent are restricted in their activities. In view of an expected increase in numbers to more than 55,000,000 older Americans in the foreseeable future, we now see the economic "tidal wave" that is developing and that soon will be upon us. A national policy is needed that makes available a combined program of social, health, and medical services in an equitable manner. The combined program aims to help older Americans function as independently as possible for as long as possible. It promotes their ability to care for themselves and to cope within the least restrictive environment.

No such integrated program is yet available. There is no precedent within existing approaches to the organization and delivery of services, which are fragmented and which focus on parts of the older person's needs rather than on the combined needs of the whole person. No national policy exists on which to change the status quo.

Recognizing the emerging national geriatric imperative, Congress originally conceived the Older Americans Act as the tool for necessary change. Congress recognized that approaches to date were piecemeal, rather than the result of an integrated and planned approach based on rational policy. For example, Medicare, Medicaid, and a series of "Titles" represented patches without a suitable framework, in which uncoordinated and inequitable financing prevailed and in which important public and private contributions were not put together. In passing the Older Americans Act, Congress recognized that the nation required energetic advocacy to change inappropriate precedents of the past which perpetuated separateness among services. Congress also recognized the need for planning and major involvement of the broad aging network - public and private; social, health, and medical; Federal, State, and local; providers, academics, and consumers. Broad involvement is critical since "the development of a truly comprehensive and coordinated system of service for older people can only be accomplished through the successful pooling and coordination" of both OAA and non-OAA resources.

With regard to the need for major involvement of the broad aging network, the the 1975 Amendments to the Older Americans Act directed the AoA to:

1. Serve as a clearinghouse for information
2. Administer grants
3. Develop plans, conduct and arrange for research
4. Assist the Secretary of Health, Education, and Welfare
5. Provide technical assistance and consultation services
6. Prepare, publish, and disseminate materials
7. Gather statistics
8. Stimulate more effective use of resources and services

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8. Stimulate more effective use of resources and services
9. Develop policies and set priorities
10. Coordinate Federal programs and activities
11. Coordinate and assist in planning and development by public and private nonprofit organizations to establish a nationwide network of comprehensive services
12. Hold conferences of public and nonprofit private organizational officials
13. Develop and operate programs not otherwise provided by existing programs
14. Continually evaluate programs and activities, paying particular attention to Medicare, Medicaid, Age Discrimination Act of 1967, and the National Housing Act
15. Provide information and assistance to private nonprofit organizations
16. Develop plans for education and training, and in consultation with the Director of Action, encourage the participation of voluntary groups including youth organizations.

With regard to advocacy, the 1978 Amendments directed the AoA to: "Serve as the effective and visible advocate for the elderly within the Department of Health, Education and Welfare and with other departments, agencies, and instrumentalities of the federal government by maintaining active review and commenting responsibilities over all federal policies affecting the elderly." In the development of policy alternatives in long-term care, the Commissioner was required to develop planning linkages and to be involved, anywhere in the federal government, with the development of long-term care health services and community health and social services for the elderly.

As the critical strategy for involving the broad aging network, Congress provided for training, research, and discretionary projects and programs through

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Title IV. This led to establishing the Gerontology Centers and to other complementing activities such as service demonstrations, training, and health promotion. The discretionary approach has been constrained and regularly at risk. In their short history, the Gerontology Centers have improved the chances for a vigorous nationwide long-term care system. For about $3 million, the Gerontology Centers have already influenced changes in the education of future health and social providers who serve the elderly. Centers continue to develop new models for alternative services, filling the gaps in the continuum of care so essential to a comprehensive, long-term care system. Communities have been assisted in replacing a cumbersome fragmented service delivery system with a single access, cooperative system of long-term care. Furthermore, the centers have supplied states in their regions with information and technical assistance that enabled them to formulate policies and design programs which will result in comprehensive long-term care systems. A noteworthy example of a contribution of the Gerontology Centers is the recent development of information about "active life expectancy" (ALE). The ALE approach can help to reshape long-term care by contributing to an improved actuarial base for financing in long-term care. It can provide normative information about the functional health of populations for use in comparative evaluations, helping to identify groups in need. It highlights the need to explore the causes and mechanisms of dysfunction as bases for improved approaches to tertiary prevention and an enhanced quality of life for elderly people. These start-up activities need to be continued to accomplish the following:

- o Establish a national long-term care policy.
- o Develop a true partnership between individuals, families, professional and voluntary organizations, foundations, and local, state and federal agencies as part of the on-going effort to address the full range of long-term care needs of older Americans.
- o Develop a full continuum of home and community-based long-term care services.
- o Implement effective disease prevention and health promotion programs.

These tasks must not be abandoned midway! Caring for the old is a problem that threatens to cripple our national economy as the U.S. elderly population doubles during the next 20 years. The Long-Term Care Gerontology Centers, by marshalling resources of the academic, medical and direct-service communities, are creating a long-term care system that enables the elderly to live independent, productive lives. Continuation and strengthening their support is essential to maintaining the full breadth of constituencies which is required to solve the nation's long-term care issues.

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Senator Pell. Thank you very much, Dr. Katz, for offering that sharp testimony.

The next witness is Jane MacKenzie, the director of the visiting nurses, executive director of the Visiting Nurse Association of Providence, Cranston, Johnston, and North Providence; and I have a particular personal admiration for the visiting nurses' service because I remember when my mother was dying the service your group used to render her. Mrs. MacKenzie.

STATEMENT OF JANE A. MacKENZIE, R.N., B.S., M.P.H., EXECUTIVE DIRECTOR OF THE VISITING NURSE ASSOCIATION OF PROVIDENCE, CRANSTON, JOHNSTON, AND NORTH PROVIDENCE

Mrs. MacKenzie. Senator Pell, I am afraid she would be retroactively denied today under medicare for that service.

Senator Pell and distinguished members of the Subcommittee on Aging, thank you for the opportunity to testify today.

In Rhode Island, the elderly population over 65 years of age comprises 13 percent of the population, compared to 11 percent nationally, or 104,000. Forty percent of those over 65, or approximately 41,600, have an impairment which limits major activity. I have given you in my testimony the Rhode Island age distribution.

But in summary, only 15 percent or 15,600 of the 104,000 elderly are below the poverty line, and according to a recent Strategic Development Commission Report, their per capita income exceeds that of the under 25 group and the group from 35 to 44. Seventy percent of the elderly are homeowners, or 72,800, and 50,960 of the 72,800 own their homes free and clear. Somewhere between 58,240 and 65,520 of the 72,800 have family.

The impact of the Older Americans Act has been significant in Rhode Island with the establishment of a wide range of services and programs as authorized under the Older Americans Act.

Our Visiting Nurse Association, which I will refer to as VNA, which serves an area which includes approximately one-third of the population of Rhode Island, works with the department of elderly affairs on the department's committee which deals with adult neglect and abuse and will receive $42,354 in 1983-84 to provide community nurse clinics at nutrition program mealsites. The VNA works with the department of elderly affairs on the concerns of the Southeastern New England Long-Term Care Gerontology Center.

The Older Americans Act of 1965 and the recommendations of the National Association of Area Agencies on Aging stress the need to develop comprehensive and coordinated service delivery systems designed to maintain elderly persons in their homes through specific planning, coordination, program development, and advocacy responsibilities. They also recommend that new structures not be created.

In neighboring Massachusetts, the area agency on aging created home care corporations establishing a system apart from the Visiting Nurse Associations. In Rhode Island we already have nine certified home health agencies. By certified I mean certified under title XVIII and title XIX. It is medicare and medicaid. Rather than create a new and separate structure—excuse me. In Rhode Island we also have nine certified home health agencies and a uniquely unfragmented home health system in place. Rather than create a new and separate structure of case management, Rhode Islanders could benefit greatly from a cooperative effort between the department of elderly affairs and the voluntary nonprofit Visiting Nurse Associations. Such an effort should not be mandated by statute, however, but our area agency on Aging perhaps would be willing to plan and monitor and help us develop supplemental and complimentary services not already available. The Visiting Nurse Associations could easily function as a home care corporation if they had the support to do so.

My only disagreement with the department of elderly affairs' in-home services program is that it duplicates our VNA's level III or basic care service which is the result of two Federal home health agency expansion grants. Approximately 400 clients are given minimal support services with an emphasis on home health aid service with a nurse as a case manager. The evaluation of the project, conducted by Brown University's Dr. Carl Granger, concluded the following:

> The population of patients on home care maintenance for chronic disease indeed is not static medically but is rather fragile, needing quite frequent hospitalization and having a known death rate of at least nineteen percent. This speaks against the commonly held notion that such a population with chronic diseases does not require active medical care.

Also:

> We have documentation to show it to be a cost-effective alternative to nursing home care; that the population served is not medically static but has changing needs for medical care.

The use of the community health nurse as case manager is an important component of long-term care, indeed, of community health care. The visiting nurse or public health nurse embracing the field of medicine and sociology has been unrecognized and underappreciated for years as providing a valuable continuity of care function in her role as case manager.

My other area of concern is the use of untrained and unsupervised homemakers/home health aides. Homemakers and home health aides are a vitally important component of long-term care. In the home health agencies, training and supervision of homemaker and aides is required. Again, it is the VNA's nurse with minimal effort who can gain access to the medical care system.

There are many services the VNA's cannot supply because of the allocation of overhead required by the medicare uniform cost reporting method. However, corporate restructuring can address this problem. Although I cannot speak for the other VNA's who are each responsible to their community volunteer boards of trustees, I am certain they would welcome the opportunity to work with the area agency on aging toward a true partnership. I believe under this model true integration of services at the community level could be achieved and that a unique and accessible, planned, coordinated system of long-term care could be achieved for all citizens of Rhode Island.

We would like to suggest that the legislation be modified to encourage the area agencies on aging to cooperate with the certified home health agency as nuclei for the development of programs that will serve the elderly. Only with these services in place will we be able to meet the increasing needs of the elderly as that proportion of our population expands. We support reauthorization of the Older Americans Act, and this is a personal, not an agency view, but I think it should come from defense.

[The prepared statement of Mrs. MacKenzie follows:]

TESTIMONY FOR

SENATOR CLAIBORNE PELL

AND

THE UNITED STATES SENATE SUBCOMMITTEE ON AGING

JANUARY 17, 1984

BY

THE VISITING NURSE ASSOCIATION
OF PROVIDENCE, CRANSTON, JOHNSTON, NORTH PROVIDENCE

JANE A. MACKENZIE, RN, BS, MPH
EXECUTIVE DIRECTOR

SENATOR PELL AND DISTINGUISHED MEMBERS OF THE SENATE SUBCOMMITTEE ON AGING, MY NAME IS JANE A. MACKENZIE, EXECUTIVE DIRECTOR OF THE VISITING NURSE ASSOCIATION OF PROVIDENCE, CRANSTON, JOHNSTON, NORTH PROVIDENCE. THANK YOU FOR THE OPPORTUNITY TO TESTIFY TODAY.

IN RHODE ISLAND THE ELDERLY POPULATION OVER 65 YEARS OF AGE COMPRISES 13 PERCENT OF THE POPULATION (COMPARED TO 11% NATIONALLY) OR 104,000. FORTY PERCENT OF THOSE OVER 65 (OR APPROXIMATELY 41,600) HAVE AN IMPAIRMENT WHICH LIMITS MAJOR ACTIVITY.

AGE	RI AGE DISTRIBUTION
65-69	42,414
70-74	33,148
75-79	23,891
80-84	15,491
85+	11,978

ONLY 15 PERCENT OR 15,600 OF THE 104,000 ELDERLY ARE BELOW THE POVERTY LINE AND, ACCORDING TO A RECENT STRATEGIC DEVELOPMENT COMMISSION REPORT, THEIR PER CAPITA INCOME EXCEEDS THAT OF THE UNDER 25 GROUP AND THE GROUP FROM 35 TO 44. SEVENTY PERCENT OF THE ELDERLY ARE HOMEOWNERS (OR 72,800) AND 50,960 OF THE 72,800 OWN THEIR HOMES FREE AND CLEAR. SOMEWHERE BETWEEN 58,240 AND 65,520 OF THE 72,800 HAVE FAMILY.

THE IMPACT OF THE OLDER AMERICANS ACT HAS BEEN SIGNIFICANT IN RHODE ISLAND WITH THE ESTABLISHMENT OF A WIDE RANGE OF SERVICES AND PROGRAMS AS AUTHORIZED UNDER THE OLDER AMERICANS ACT.

OUR VISITING NURSE ASSOCIATION (VNA) WHICH SERVES AN AREA WHICH INCLUDES APPROXIMATELY 1/3 OF THE POPULATION OF RHODE ISLAND, WORKS WITH THE DEPARTMENT OF ELDERLY AFFAIRS ON THE DEPARTMENT'S COMMITTEE WHICH DEALS WITH ADULT NEGLECT AND ABUSE AND WILL RECEIVE $42,354 IN 1983 TO PROVIDE COMMUNITY NURSE CLINICS AT NUTRITION PROGRAM MEAL SITES. THE VNA WORKS WITH THE DEPARTMENT OF ELDERLY AFFAIRS ON THE CONCERNS OF THE SOUTHEASTERN NEW ENGLAND LONG TERM CARE GERONTOLOGY CENTER.

THE OLDER AMERICANS ACT OF 1965, AND THE RECOMMENDATIONS OF THE NATIONAL

ASSOCIATION OF AREA AGENCIES ON AGING, STRESS THE NEED TO "DEVELOP COMPREHENSIVE AND COORDINATED SERVICE DELIVERY SYSTEMS DESIGNED TO MAINTAIN ELDERLY PERSONS IN THEIR HOMES THROUGH SPECIFIC PLANNING COORDINATION, PROGRAM DEVELOPMENT AND ADVOCACY RESPONSIBILITIES." THEY ALSO RECOMMEND "THAT NEW STRUCTURES NOT BE CREATED."

IN NEIGHBORING MASSACHUSETTS, THE AREA AGENCY ON AGING CREATED HOME CARE CORPORATIONS ESTABLISHING A SYSTEM APART FROM THE VISITING NURSE ASSOCIATIONS. IN RHODE ISLAND WE ALREADY HAVE NINE (9) CERTIFIED HOME HEALTH AGENCIES AND A UNIQUELY UNFRAGMENTED HOME HEALTH SYSTEM IN PLACE. RATHER THAN CREATE A NEW AND SEPARATE STRUCTURE OF CASE MANAGEMENT, RHODE ISLANDERS COULD BENEFIT GREATLY FROM A COOPERATIVE EFFORT BETWEEN THE DEPARTMENT OF ELDERLY AFFAIRS AND THE VOLUNTARY NON-PROFIT VISITING NURSE ASSOCIATIONS. SUCH AN EFFORT SHOULD NOT BE MANDATED BY STATUTE HOWEVER, BUT OUR AREA AGENCY ON AGING PERHAPS WOULD BE WILLING TO PLAN AND MONITOR AND HELP US DEVELOP SUPPLEMENTAL AND COMPLEMENTARY SERVICES NOT ALREADY AVAILABLE. THE VISITING NURSE ASSOCIATIONS COULD EASILY FUNCTION AS A HOME CARE CORPORATION IF THEY HAD THE SUPPORT TO DO SO.

MY ONLY DISAGREEMENT WITH THE DEPARTMENT OF ELDERLY AFFAIRS IN-HOME SERVICES PROGRAM IS THAT IT DUPLICATES OUR VNA'S LEVEL III (OR BASIC CARE) SERVICE WHICH IS THE RESULT OF TWO FEDERAL HOME HEALTH AGENCY EXPANSION GRANTS. APPROXIMATELY 400 CLIENTS ARE GIVEN MINIMAL SUPPORT SERVICES WITH AN EMPHASIS ON HOME HEALTH AIDE SERVICE WITH A NURSE AS CASE MANAGER. THE EVALUATION OF THE PROJECT, CONDUCTED BY BROWN UNIVERSITY'S DR. CARL GRANGER, CONCLUDED THE FOLLOWING: "THE POPULATION OF PATIENTS ON HOME CARE MAINTENANCE FOR CHRONIC DISEASE INDEED IS NOT STATIC MEDICALLY BUT IS RATHER FRAGILE, NEEDING QUITE FREQUENT HOSPITALIZATION AND HAVING A KNOWN DEATH RATE OF AT LEAST 19%. THIS SPEAKS AGAINST THE COMMONLY HELD NOTION THAT SUCH A POPULATION WITH CHRONIC DISEASE DOES NOT REQUIRE ACTIVE MEDICAL CARE"...ALSO "WE HAVE DOCUMEMTATION TO SHOW IT TO BE A COST-EFFECTIVE ALTERNATIVE TO NURSING HOME CARE; THAT THE POPULATION SERVED IS NOT MEDICALLY STATIC BUT HAS CHANGING NEEDS FOR MEDICAL CARE."

THE USE OF THE COMMUNITY HEALTH NURSE AS CASE MANAGER IS AN IMPORTANT

COMPONENT OF LONG TERM CARE, INDEED OF COMMUNITY HEALTH CARE. THE VISITING NURSE, IN BRIDGING THE FIELDS OF MEDICINE AND SOCIOLOGY, HAS BEEN UNRECOGNIZED AND UNDER APPRECIATED FOR YEARS AS PROVIDING A VALUABLE CONTINUITY OF CARE FUNCTION IN HER ROLE AS CASE MANAGER.

MY OTHER AREA OF CONCERN IS THE USE OF UNTRAINED AND UNSUPERVISED HOMEMAKERS/HOME HEALTH AIDES. HOMEMAKERS AND HOME HEALTH AIDES ARE A VITALLY IMPORTANT COMPONENT OF LONG TERM CARE. IN THE HOME HEALTH AGENCIES, TRAINING AND SUPERVISION OF HOMEMAKER AND AIDES IS REQUIRED. AGAIN IT IS THE VNA NURSE WITH MINIMAL EFFORT WHO CAN GAIN ACCESS TO THE MEDICAL CARE SYSTEM.

THERE ARE MANY SERVICES THE VNA'S CANNOT SUPPLY BECAUSE OF THE ALLOCATION OF OVERHEAD REQUIRED BY THE MEDICARE UNIFORM COST REPORTING METHOD. HOWEVER, CORPORATE RESTRUCTURING CAN ADDRESS THIS PROBLEM. ALTHOUGH I CANNOT SPEAK FOR THE OTHER VNA'S WHO ARE EACH RESPONSIBLE TO THEIR COMMUNITY VOLUNTEER BOARDS OF TRUSTEES I AM CERTAIN THEY WOULD WELCOME THE OPPORTUNITY TO WORK WITH THE AREA AGENCY ON AGING TOWARD A TRUE PARTNERSHIP. I BELIEVE UNDER THIS MODEL, TRUE INTEGRATION OF SERVICES AT THE COMMUNITY LEVEL COULD BE ACHIEVED AND THAT A UNIQUE AND ACCESSIBLE, PLANNED, COORDINATED SYSTEM OF LONG TERM CARE COULD BE ACHIEVED FOR ALL CITIZENS OF RHODE ISLAND.

WE WOULD LIKE TO RECOMMEND THAT THE LEGISLATION BE MODIFIED TO ENCOURAGE THE AREA AGENCIES ON AGING TO COOPERATE WITH THE CERTIFIED HOME HEALTH AGENCIES AS NUCLEI FOR THE DEVELOPMENT OF PROGRAMS THAT WILL SERVE THE ELDERLY. ONLY WITH THESE SERVICES IN PLACE WILL WE BE ABLE TO MEET THE INCREASING NEEDS OF THE ELDERLY AS THAT PROPORTION OF OUR POPULATION EXPANDS.

THANK YOU.

Senator PELL. I would just like, I must say I concur with you on that. Following up on your first remark, why would somebody not be able to get visiting nurse service if they paid for it at home still? I don't understand what the difficulty would be. You said my mother could not receive that service now.

Mrs. MACKENZIE. We are now under intensive utilization review by medicare. Home health services under medicare account for approximately 2 percent of the medicare budget, as I am sure you know. Our agency happens to be the target, one of the last large agencies in New England to be designated by the utilization review teams. There are more stringent interpretations of the regulations in effect now than the fiscal intermediaries have exercised in the past.

Senator PELL. But without medicaid getting into it, can't the individual pay for that service privately?

Mrs. MACKENZIE. If they can afford it, yes. But sickness knows no economic barriers.

Senator PELL. I would agree with that. Now, this is one of the things that I am always struck by. The very sick and the old and the poor are not visible, not here, not in the streets, because as a rule they are tucked away in their abode, wherever that is, and we forget the misery that is not visible as a rule. It is invisible, and only those of us like yourself who search it out know that that misery is there and exists.

Sr. Ruth, are there more people who would like to be served by your center who you just don't have room for?

Sr. CRAWLEY. Definitely. We started 10 years ago in 1973—I'm sorry. Ten years ago we started with seven patients or participants, as we call them; and over the years we increased to the present day——

Senator PELL. I must say I like your phrase "participant." The word "client" sort of turns me off sometimes. Maybe it could be copied.

Sr. CRAWLEY. Over the years, we have increased gradually, 20, 30, 40, and we are now up to 50, a day. We have 62 people we service now every month because some don't come every day if they are not warranted by their physician or the team, and they don't need to. Some come 2 days, 3 days, 4 days, and 5. But we have a waiting list at all times, and that's why we have been taking more; but we have now reached our capacity, and we will not take any more than 50 because it will require additional staff, and we don't have the money.

Senator PELL. Thank you very much. Dr. Katz, I was very struck with your viewpoint on the quality of life. And here, I recall from my friends in Rhode Island, a visit I made to the Soviet Union a few weeks ago, and we went down to Tbilisi, Georgian SSR. I talked there with a group of individuals, all of whom were over 100, all of whom were very vigorous, fresh, looked just like you and I do; and I was asking them what their common denominator is—rather, I asked the gerontologist, the head of the university faculty there, and he said it was a question of outlook, happiness, diet, no meat, hardly any eggs, they drank a lot of wine and vodka. They lived a full life. I was just curious, speaking to you as a gerontologist, why can't we do the same in our country? Why do we not have groups of people whose quality of life is excellent when they are over 100?

Dr. KATZ. That group that you are talking about in Georgia has been studied by sociologists, and genetics is a part of it which you don't fix with environmental factors. On the other hand, there is a lot that we can do. A couple of very simple points to illustrate how we might promote well being. One is, I say to all of us we put a glass on the shelf and we reach for it to get a glass of water. Maybe we ought to put it on the second shelf so that we can reach and stretch that arm every morning. Instead of making things easier. And when we speak to the aged, we, ourselves I am talking about, we try to get this mental set that although we'd like to have other people help us and although we worry about aches, maybe we should keep other people from helping us as long as possible when we don't need it, and maybe the ache isn't as bad. This is a philosopher speaking. Maybe the ache isn't as bad as being dysfunctional, being laid up and stiff in bed.

These kind of simple measures are in the knowledge of physical therapists today, of nurses who run visiting nurse programs, of health educators; and it's interesting that it's not systematically spread through our society yet. Health promotion is a very—about $30 billion goes into NIH. Not much goes into health promotion for the older.

Senator PELL. I wonder, do you happen to know how many centenarians do we have in Rhode Island?

Dr. KATZ. I can't answer that.

Senator PELL. Mrs. Tucker knows.

Mrs. TUCKER. 169.

Senator PELL. 169 people over 100 years of age. And how many of that 169 are able to lead a full life like the people I saw in Georgian SSR.

Mrs. TUCKER. Every year the Governor has a May breakfast, and this year there were 29 people who were able to come and have breakfast with the Governor. Three of them are 107 years of age.

Senator PELL. So I think that we should set our targets a little higher.

Dr. KATZ. We can do it now.

Senator PELL. I think, Dr. Katz, you put your finger on one point, and that is that one should have function. I noticed that each one of these older people had a function, might be to just go out and feed the chickens, but they had a function and they were needed and they were respected.

Dr. KATZ. Yes, sir.

Senator PELL. I would also like to ask you another question that's often bothered me, and that is, Is it a good thing for older people to be living by themselves in housing for the elderly or would it be better in the family unit?

Dr. KATZ. I think it is better in the family unit and social settings where they are actually encouraged. We showed it in experiments some years ago that we could slow mental deterioration by maintaining a stimulated active life.

Senator PELL. I would like to ask this question of the audience that is here, the witnesses of the witnesses. How many of you believe that your life would be extended if you stayed as a family unit and how many of you believe that you would be better off living in a housing for the elderly? First, how many believe you would be better off in the housing for the elderly with your own privacy? And how many believe in living in the family unit?

[The majority of the audience indicated that they would prefer living in the family unit.]

Senator PELL. Very interesting indeed, and I think rather instructive to the community. Time is racing by, but, Dr. Katz' testimony stimulated me so much. Your study on active life expectancy, when will its results be out or are they out?

Dr. KATZ. It has been reported in the New England Journal of Medicine this past November, and the Institute of Medicine is working with others to implement such information systems throughout the country.

Senator PELL. Good. I shall educate myself by reading it. And now to Mrs. MacKenzie. No, wait a second, please. Mrs. MacKenzie, could you describe the different kind of services that your group, your association, offers patients. Participants rather than clients.

Mrs. MACKENZIE. Yes. We get accused of calling everyone a patient. So we got sensitive about that. Then we changed it to client. They are actually people who do participate in their care, and we do have a rehabilitation model. In other words, we do believe that everyone who can do something for themselves should do that. That's an expensive approach, but it's a very necessary sort of a support. This is what we mean by health maintenance. That if you can still tie your own shoe, you ought to tie your own shoe and not have the home health aide tie your shoe for you.

Senator PELL. And preferably put your sock on while standing on one leg to do it.

Mrs. MACKENZIE. Exactly. Your question again?

Senator PELL. The kinds of services that you offer.

Mrs. MACKENZIE. Nursing, speech therapy, physical therapy, medical social work, nursing, home health aide which is the same as homemaker, home health aide. We have just diversified and broken up our corporation in order to be able to provide tour services and other planned activities. Where we are going to get the money, I am not quite sure. But these are needed to help elderly people stay at home if that's where they want to be, and they are appropriate and medically able to be there.

Senator PELL. I want to be sure I heard correctly. You said under medicare you can no longer render those services and have them paid by medicare?

Mrs. MACKENZIE. No. Medicare is very, very stringently reinterpreting their regulations. In other words, what they consider as skilled nursing care is more stringently defined. What they will consider as homebound is incredible. You have to go out on a stretcher to be considered essentially homebound. In order to—the definition of rehabilitable, we've had terminally ill patients who needed home health aide service at night the last 3 days of dying and being denied.

Senator PELL. Then what you are saying is the act is all right, but it is the regulations that are wrong?

Mrs. MacKenzie. It is the new interpretation of the regulations. The regulations are fine as long as the professional is allowed to interpret those with the best interest of the participant in mind.

Senator Pell. I would be grateful if you would write me a formal letter, unless you have done it at the national level, write a formal letter to me so that we can at least give a little push on this to the department.

Mrs. MacKenzie. I believe we are also maybe invoking the Paper Burden Act because we are being reviewed by every single record, and we have approximately 1,500 people on our caseload every day. That means every 30 days a complete summary of that patient record has to go in to the fiscal intermediary. I have had to hire two to three more staff in order to do this, and it is taking up extra computer time.

Senator Pell. Let me add to your paper burden a little bit, and give me a letter with specific complaints or observations of this sort and I will follow up and do my best.

Mrs. MacKenzie. Thank you.

Senator Pell. Thank you very much.

[Brief recess.]

Senator Pell. The committee will come back in session. Can there be quiet, please. It is the intention of our subcommittee to hold a hearing on this question of longevity and the quality of life, and we are making preparations or hoping to make preparations in this regard, hoping to do this sometime this year. That will probably take place in Washington.

The next witnesses we have are Joan Soucy, executive director of Senior Inn, Inc.; and Sybil Kaplan, nutritionist at URI Cooperative Extension. If they would come forward. Joan Soucy, thank you, and Sybil Kaplan.

Joan Soucy is the director of Senior Inn, Inc., in Pawtucket, and would she please proceed.

STATEMENT OF JOAN C. SOUCY, EXECUTIVE DIRECTOR OF SENIOR INN, INC., PAWTUCKET, RI

Mrs. Soucy. Yes, thank you. As the Senator indicated, I am Joan C. Soucy, executive director of Senior Inn, Inc., in Pawtucket. We are a private, nonprofit, social service agency which administers, among other things, the nutrition program for the elderly in area I of Rhode Island which is one of six areas. My communities that we serve are Pawtucket, Central Falls, North Providence, and Johnston. I also serve as the president of the Rhode Island Directors Association for Community Focal Points and also am the delegate to the National Association on Nutrition and Aging Service Programs.

I would like to thank Senator Pell for inviting me to speak here.

Here in Rhode Island we are proud that we have the distinction of having been the first State in New England to receive old title VII nutrition moneys back in September of 1973. Senior Inn, Inc., was the first grantee of these nutrition dollars in Rhode Island, having had a program, and I am happy to say 13 years ago today we served our first meal.

Rhode Island has done well by the single State PSA, planning service area, concept of designation of area agency on aging. There is only one, and the State is the AAA. This has resulted in open lines of communication between the State staff and the local agencies. It also has resulted in a savings of AAA administrative dollars which are allowable up to 8½ percent for administration which have been pumped into other services for the elderly by the State of Rhode Island since it uses its flat allocation of $400,000 for its administration.

I have outlined the growth of the nutrition program in Rhode Island over the last 10 years both in the congregate program as well as the home-delivered meals program.

Back in 1973, which was the first year nutrition programs were funded, the State of Rhode Island served a total of 210,000 meals, of which 31,500 were home delivered. That's 123 a day on the average; 178,500, or a daily average of just under 700 a day, were served in social settings, churches, at that point senior centers, et cetera. In 1983, the last fiscal year, the State of Rhode Island served 1,051,645 meals, of which 1,113 on a daily average were served to homebound individuals. That was 285,082 meals as opposed to 31,500 served in a 10-year period. That's an increase of 28 percent there. Also, in the congregate program there were a total of 766,563 meals served statewide in senior centers and nutrition centers around the State. That breaks down to a daily average of just under 3,000 meals a day.

There has been substantial growth, and I believe the growth in home-delivered meals is the direct result of separate funding for nutrition programs under title III–C–1 which is congregate or III–C–2 which is home delivered.

All of the menus here in Rhode Island have been planned by either a food service manager or food dietician affiliated with the project with input from participants and contain certain or sometimes ethnic preferences. The menus are then submitted for review and approval by the State nutritionist. She evaluates them for adherence to the nutrient content and the one-third RDA. We have found no evidence of need for special diets at this point.

Rhode Island's nutrition programs are administered by three nonprofit agencies and three community action programs. Our home-delivered meals program is included among the nonprofits. It is administered statewide by Rhode Island Meals on Wheels, Inc., which is also the grantee for the congregate program in Providence. Assessments for the eligibility of homebond is done at the local level by nutrition program staff. We also in Rhode Island have three central kitchen facilities which prepare meals and ship them out in bulk to various sites, and three others using caterers or a caterer on site in part.

My particular project has noticed a significant decrease in the number of meals served in the Pawtucket area especially; and after some investigation, I found that the participants, excuse me, are utilizing the free soup kitchens on the days when they are available. There is one very large one being served right now in Central Falls and one in Pawtucket. I believe that the HHS initiative of urging participants of Older American Act's services to contribute toward the cost of every service is forcing them out of the program because they are too proud not to donate the same amount as their peers and limit their participation. In many instances these are the persons most in need of the nutritious, balanced meal and other programs.

The nutrition program is more than just a meal. It is a nutrition center. We provide a gamut of services under the nutrition moneys. The last amendments to the Older Americans Act allowed project income to be used for other access services which is going back to the old title VII. We offer outreach counseling, transportation, nutrition education, recreation activities, opportunities for volunteerism, and employment.

With regard to the reauthorization of the Older Americans Act, I would like to recommend that the maintenance of separate funding sources and separate titles be maintained. Also, that there be the continuation of the provision for voluntary contributions and the nonfinancial eligibility, no means test. Also that there be open lines of communication between all sections of the aging network, in particular, the Federal level. That the Commissioner on Aging be elevated to the status of Assistant Secretary in order to provide the necessary leadership and authority over the Older Americans Act. Also, we would like to see something more specific in the way of what must be evaluated in the competitive bid process. The regulations right now do not address that very clearly. We would support additional services and less administrations. I think Mrs. MacKenzie indicated that in Massachusetts there are a number of AAA's and a number of home care agencies. The area agencies are allowed to take up to 8½ for administration. Here in Rhode Island that's different. All of that money goes into services. We would like to see that more on the national level.

The regulations make very little mention of minority and rural needs. We feel that these should be addressed more specifically either in the act or in the regulations themselves. We support wholeheartedly the Senior Community Employment Service Program. Not only as it is now as a training program, but also to continue it as a jobs program. In my particular area in my nutrition program, we have hired six former senior employment service people. They are part of our regular staff currently. We support the role wholeheartedly of the area agency on aging, but not as the first choice for the delivery of direct services. Again, not pertaining to Rhode Island, but the rest of the country, where there is a proliferation of area agencies on aging, and it was the assumption that there would be more area agencies on aging to administer programs. We also support the full spectrum of services for the aging, not only the meal. Thank you.

[The prepared statement of Mrs. Soucy follows:]

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Joan C. Soucy
Director

I am Joan C. Soucy, Executive Director of Senior Inn, Inc. a private non-profit social service agency which administers the nutrition program for the elderly in Area I, which includes the communities of Pawtucket, Central Falls, No. Providence and Johnston. I am also president of the R. I. Directors Association for Community Focal Points and the Rhode Island delegate to the NANASP Board of Directors.

My sincere thanks to Senator Pell and his staff for inviting me to speak today on the reauthorization of the Older Americans Act.

We are proud that Rhode Island has the distinction of having been the very first state in New England to receive Title VII funds back in 1973. Senior Inn, Inc. was the first grantee of these nutrition dollars in Rhode Island.

Rhode Island has done well by the single state PSA concept of designation of Area Agency on Aging. This has resulted in open lines of communication with State staff and a savings of AAA administrative dollars (up to 8 1/2% allowable) which have been pumped into services since Rhode Island uses the flat administrative dollars disbursed under the federal formula.

I have outlined the growth of the nutrition program in Rhode Island over the last 10 years both in the congregate and home delivered meals program.

Direct Services *Energy* *Nutrition* *Transportation*

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FY	TOTAL MEALS	CONGREGATE	DAILY AVE.	HOME DELIVERED	DAILY AVE.	% OF
73	210,000	178,500	697	31,500	123	15%
75	275,968	220,775	862	55,193	215	20%
83	1,051,645	766,563	2,994	285,082*	1,113	28%

*under separate funding level

All of the menus served in Rhode Island have been planned by a food service manager or dietician affiliated with the project with input from participants and contain some ethnic preferences. The menus are then submitted for review and approval of the State Nutritionist. She evaluates them for adherance to the nutrient content and 1/3 RDA. We have found no evidence of need for special diets.

Rhode Island's nutrition programs are administered by three non-profit agencies and three community action programs. The home delivered meals program is included among the non-profits and is administered state-wide by R. I. Meals on Wheels, Inc. Assessments for eligibility is done at the local level by the nutrition program staff.

Also, three of the nutrition programs prepare in central kitchen facilities or on site, with the other three using commercial caterers in total or in part.

In my particular project I have noticed a significant decrease in the number of meals served and have, after some investigation, found that these participants are utilizing the free soup kitchens on the days that they are available. I believe that the HHS initiative of urging participants of OAA services to contribute towards the cost of every service is forcing them out of the program because they are too proud not to donate the same amount as their peers and limit their participation. In many instances these are the persons most in need of the nutritious, balanced meal and other programs.

Regarding the reauthorization of the Older Americans Act we propose consideration of the following recommendations:

-Maintain the distinct identity of nutrition programs

-Continuation of voluntary contributions and nonfinancial eligibility

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-Open the lines of communication between all sections of the aging network.

-Elevate Commissioner on Aging to status of an Assistant Secretary in order to provide leadership and authority.

-Specify what must be evaluated in "competitive process".

-Support services, not administrations.

-Specify minority and rural needs.

-Support senior community employment as just that and drop the current emphasis on training for placement for other jobs.

-Support the role of the Area Agency as not the first choice in the delivery of direct services.

-Support a full spectrum of services.

Thank you for this opportunity to speak on behalf of my colleagues who administer the nutrition programs in Rhode Island.

Senator PELL. Thank you very much. Now, Sybil Kaplan, Nutritionist at URI Cooperative Extension.

STATEMENT OF SYBIL DAVIS KAPLAN, NUTRITIONIST, URI COOPERATIVE EXTENSION, KINGSTON, RI

Mrs. KAPLAN. Thank you. My name is Sybil Davis Kaplan, and I am a registered dietician, but not a practitioner at this point in time. Since 1963 I have been the cooperative extension specialist in food and nutrition based in the college of resource development at the University of Rhode Island.

The elderly population in the United States has been increasing, and this trend is——

Senator PELL. Will you talk a little louder. There are some that can't hear you.

Mrs. KAPLAN. How's that?

Senator PELL. OK.

Mrs. KAPLAN. The elderly population in the United States has been increasing, and this trend is predicted to continue into the next century. This fact points up the need to promote the well-being of the elderly in order to either prevent or delay the need for institutionalization which would be a great financial burden to families as well as the Government.

A number of dietary studies have shown that several nutrients are often low in the diets, that is, food intake, of the elderly. These include calcium, thiamin, ascorbic acid, and vitamin A. Other large national surveys have found the mean caloric intake of the elderly below the standard used.

In 1981, a colleague, Phyllis T. Brown, associate professor, conducted a study entitled, "Dietary Status, Food Habits and Food Preferences of Participants in the Title III Group Meals" here in Rhode Island. It can be concluded from these data that the group meals were extremely important for this group of elderly subjects, especially the males, in providing an adequate diet. The females should be encouraged to eat more foods containing calcium both at the meal sites and at home.

While the serving of nutritious meals is essential, the title III group meals also provides social interaction which plays an important role in the nutritional status of the elderly. However, there is a need for innovative nutrition education. The old adage concerning the feeding of a hungry person versus teaching that person how to fish so that he can care for himself when we are not here to do it deserves consideration. Phyllis Brown's study indicated the difference between the days when people ate the title III meals versus the days they ate at home.

Unfortunately, most of the nutritional problems the elderly possess are the results of many years of faulty food habits. For example, many elderly women have eaten calcium deficient diets for years. As a result, they have osteoporosis. The obesity exhibited by some elderly is again the result of years of faulty food habits. While nutrition education should be a part of the title III meals program, the objectives should be specific, namely help the elderly select appropriate foods for breakfast and supper meals as well as breakfast, dinner, and supper on those days when they are not participating in the group meal.

I would like to mention at this point that the bulk of my time for the past 5 years has not been spent directly with the elderly. It became apparent at least 5 years ago that as our population aged, if we didn't do a lot of in-depth teaching among our younger people, that we would have even more problems than the elderly are exhibiting today. So my time has been put primarily working, trying to prevent some of the problems that many of our elderly in Rhode Island exhibit. I would like to thank you very much for the opportunity to participate at this hearing.

Senator **Pell**. Mrs. Kaplan, I would like to followup on that thought. What means are being used to educate middle-aged people as to what the correct diet is? For instance, you have mentioned it should have calcium in it. The normal way to get calcium is to drink milk; but if you drink too much milk, you have too much cholesterol. Who makes this information known?

Mrs. **Kaplan**. By way of the cooperative extension based at the university, we have home economists who are based at the local level; and my responsibility is to keep the home economists up to date in the area of nutrition. And we have many community groups meeting and are teaching the basics of appropriate food intake. We also do quite a bit of writing for the media and are on radio and television in addition.

Senator **Pell**. But what is the answer to the specific question I put to you there?

Mrs. **Kaplan**. My answer is that there are many dairy products, and whole milk is only one. We also have low-fat milk and we have skim milk. We have low-fat cheeses that can be used as a substitute for milk. One of the recommendations that I would make, at the risk of displeasing some of the eaters, is that if at our meal sites, for example, we served more lower fat milk, and more lower fat meals, I think everybody would be better off.

One of the problems, approximately 50 percent of the population is overweight to some extent. Some people are much more overweight. And people need in this country—I was interested when you mentioned your trip to Georgian in Russia, even among low-income groups, as a nation we are taking in much too much fat, much more sugar than is necessary, and much more from the protein group, the meat and the fish and the chicken and the eggs. It's just a matter of taking in disproportionate amounts of carbohydrate, protein, and fat.

Senator **Pell**. I am struck by what you are saying. I know I stopped eating red meat 5 years ago and felt much better for it. But the question is to get this information out to the people. I have always been struck with the fact that the military academies at West Point and Annapolis give our young people meat and milk and all of this. That's fine. They have a full life in the service with these eating habits, and then they retire and they die a few years later. You feel the Government is almost doing it to shorten the retirement period.

Mrs. **Kaplan**. One of the problems is that as younger people, we can tolerate more of these what I call nutritional affronts because we are more active.

Senator **Pell**. But nothing is being done. I have been on the visiting committee at Annapolis, for instance, where they feed these poor young men this food, and I am sure many people do it with their children. You are putting in your children the seeds for early heart disease and early death.

Mrs. **Kaplan**. One of the items that I would like to see addressed is that earlier and earlier we get information out to people about the fact that good food is important; but this is not necessarily to be equated with large quantities. While I wouldn't advocate eliminating red meat entirely or eggs or butter or margarine——

Senator **Pell**. Why not?

Mrs. **Kaplan**. Because I think that we need variety in order to get all of the nutrients that we need. The other thing is I would not like to see us legislate good nutrition, not counting the problems that this would bring about. I would like to see us give people alternatives. And if you have somebody who does need the calories and who enjoys whole milk, fine, but the larger proportion of people require fat-reduced meals.

Senator **Pell**. That is what accounts for the fact that always disturbs me, that you find people who are very much overweight who still are presumably underfed.

Mrs. **Kaplan**. This is very true.

Senator **Pell**. You can be both overweight and underfed.

Mrs. **Kaplan**. Poorly fed rather than using the word "underfed." The other point that I would like to make is that I feel in Rhode Island we do not have enough—and this is where I would like to put my registered dietician hat on—we do not have enough diet counseling available to our people. Particularly the need for therapeutic diets among some of our elderly. I realize that in the meal settings Joan Soucy said that we do not have large needs for therapeutic diets. We still have enough so that I think that qualified, registered dieticians should be available at the community level to counsel those people who do not get this information by way of the private physician or through some other community group.

Senator **Pell**. I would agree with you very much. And, turning to Mrs. Soucy, you mentioned, for instance, the kitchen in Central Falls. Is that the one in the basement of the church?

Mrs. **Soucy**. Yes.

Senator **Pell**. I have been there and visited there and like what they are doing. But bearing out the point that Mrs. Kaplan just mentioned, I asked if there was a dietician there when they made their dietary decision as to what to eat, and there really wasn't one when I was there.

Mrs. Soucy. That's right, there is none.

Senator Pell. So I think that you have a job to do and more outreach on the spot. If you just went by one of your people once a week or once a month, I think it would give them the idea of what would be a better diet. Now, how can we encourage our seniors to make more use of the meal sites? In spite of what Mr. Meese says, there are elements of hunger in our State. What can we do to encourage people to go to the meal sites?

Mrs. Soucy. What we need is more money for outreach. There is very little money in the nutrition dollars for outreach. We are staffing right now three part-time outreach workers which is down from seven when we had the old title VII.

Senator Pell. You mentioned in your statement to stress minority needs and rural areas. There are no rural areas in Rhode Island.

Mrs. Soucy. There are some rural areas in Rhode Island.

Senator Pell. But we also have a large minority population. What can be done to meet these needs?

Mrs. Soucy. I think the regulations have got to be a little bit more specific in perhaps setting percentages as minimums in serving minority people.

Senator Pell. Incidentally, you are quite right. We do have rural areas. I was thinking more from the viewpoint of the productivity of the State. It is not as dependent on agricultural products as other States.

Mrs. Soucy. Our rural community does not meet the Federal guidelines.

Senator Pell. You go up to the northwest part of the State, and it is certainly a very remote part of the world.

Mrs. Soucy. It certainly is.

[The following statement was received for the record:]

Rhode Island Meals On Wheels Inc.
"WE CARE"
175 Mathewson Street
Providence, Rhode Island 02903
Tel. 351-6700

JOSEPH N. BROWN
Executive Director

TESTIMONY--SUBCOMMITTEE ON AGING--
North Providence Senior Center, North Providence, R. I.
January 17, 1984

Good Morning. I am Joseph Brown, founder and Executive Director of R. I. Meals on Wheels.

First, I want to express my appreciation again to Senator Pell for his strong support of R. I. Meals on Wheels and the Older Americans Act (I was invited and did testify in Washington several years ago in support of the reauthorization of the Older Americans Act and Senator Pell kindly had that testimony printed in the Congressional Record and sent out for general distribution).

R. I. Meals on Wheels is a program inspired by an attempt to solve one of the most pressing problems of our elderly shut-ins—that of obtaining proper nutrition.

Many of these elderly people are able to care for their needs in their own homes except to prepare proper food for themselves. For some it is physically impossible to cook; others have become apathetic about cooking for themselves and suffer as a result from malnutrition.

There are hundreds of these homebound, handicapped and convalescent elderly whose greatest desire is to remain independently in their own homes. They can do so with just a little outside help, and this is where Meals on Wheels and the Older Americans Act comes in - into the home five days a week with a hot meal consisting of soup, crackers, salad, meat, potato, vegetable, bread and butter, dessert and milk.

R. I. Meals on Wheels started fifteen years ago on a hundred dollar donation from each of the five downtown churches. We started with 17 clients and ten volunteers; today we have over 700 volunteers along with three paid drivers who altogether are delivering over 1200 meals a day to the homebound elderly throughout the state. R. I. Meals on Wheels is the only statewide program in the United States and is one of the largest in the country. In 1983 we delivered 293,732 meals to the homebound—this is in addition to about 800 meals a day (or 220,337 for the year) congregate meals that we are serving at 17 meal sites in Providence, for a grand total of 499,676 meals for the year. This has been made possible by the combined efforts of a large, voluntary, private, non-profit organization including hundreds of dedicated volunteers and the strong financial support and direction from the public sector--the Governor's office, the State Legislature, the R. I. Department of Elderly Affairs, and the Federal Government through the Older Americans Act. These combined efforts have resulted in one of the finest programs in the country.

I strongly recommend the following:

1. That the Older Americans Act be reauthorized but for a period of five years rather than three years.

2. That it be funded at least at the current level and with a built-in yearly inflation factor. This will enable the service providers to maintain the present quality of service.

3. That there be no rewording of the Act that would result in the requirement of any form of a means test. The elderly have a lot of pride and dignity, and this program must not be allowed to become a welfare program.

4. Wording in the Act should clearly indicate that the "Aging Network" is made up of both the private volunteers and community-based sector and the public, governmental sectors. Both must work together if the needs of the elderly are going to be met. I believe Rhode Island is an example for the whole country in showing how the two can effectively work together. We have had an outstanding relationship with the Governor's office, the State Legislature, and the Department of Elderly Affairs.

5. Integration in home-delivered meals of the preparation of the meal, delivery of the meal, assessment of the need, and provision of emergency and supportive services.

6. The nutrition program has been so successful under the Older Americans Act that care must be taken that it retain its own identity.

Thank you for this opportunity to strongly endorse the reauthorization of the Older Americans Act.

Senator PELL. Thank you both very much for being with us. We must hurry along because I understand that some of these tables will be needed for luncheon later.

Our next witnesses are Corinne Russo who is really our hostess here today, the director of the North Providence Senior Center; and Ann Hill, director of St. Martin dePorres Senior Center, and a member of the National Center and Caucus on Black Aged. We will start out, I guess, with Mrs. Russo. And thank you very much for your hospitality, and I hope we don't impose on you by staying here too long so that you can't feed your people which can happen if we stay here too long.

STATEMENT OF CORINNE CALISE RUSSO, DIRECTOR OF THE NORTH PROVIDENCE SENIOR CITIZENS CENTER, INC.

Mrs. RUSSO. You are indeed very welcome. We are indeed very happy to have been able to host this hearing, Senator Pell. I am sure that having very flexible staff we will be able to work around your schedule.

Senator Pell, committee members, and honored guests, I have submitted written testimony to the Senator, and I will pull from my testimony in order to make the presentation brief.

Senator PELL. I would add the full statement will be inserted, included in the record.

Mrs. RUSSO. Fine. I am honored to have been given this opportunity to present testimony relating to the reauthorization of the Older Americans Act of 1965.

As we approach the reauthorization process, my colleagues and other professionals who are involved in the senior center movement urge you, who are involved in that process, to examine the unique and positive aspects of programs developed under the Older Americans Act while preserving its special qualities.

My colleagues, including the National Institute of Senior Centers, feel that numerous questions regarding congressional intent can be answered by expanding and clarifying that part of title III which contains definitions. Some terms commonly used are not defined in the act. Of greater importance, such terms as "multipurpose senior centers" and "community focal points for service delivery" which are currently defined elsewhere in the act should be included in title III, definitions, section 302, in order that title III and its corresponding regulations are consistent in their language.

The definition of "multipurpose senior centers" currently in section 321(b)(1) of the act and section 1321.3 of the March 31, 1980, regulations adequately describes what senior centers are, and that language should be retained.

A revised definition of community focal point for service delivery as recommended by the National Council on the Aging and acceptable to professionals in Rhode Island is as follows:

> A facility or mobile unit within a defined community which provides older persons with maximum direct access to available services, in a fashion acceptable to them, by encouraging co-location and coordination of services for older individuals. Community focal points for service delivery shall be designated by the state or area agency, which shall give considerations to designating multipurpose senior centers as such focal points.

Because of conflicting interpretation, the lack of other sections of the act should be modified to clarify what the original congressional intent was.

Section 321(a) identifies many necessary and needed supportive services for which the Commissioner shall make grants to the States in order for these services to become available to the elderly. However, in section 321(b)(2) the act states that "funds made available to a State under this part may be used, for the purpose of assisting in the operation of multipurpose senior centers, to meet all or part of the costs of compensating professional and technical personnel required for the operation of multi-purpose senior centers." This section should be revised to make it clear that funds allocated may be used for all legitimate operational costs to a multi-purpose senior center. Examples, the staff of this agency is constantly called upon by children of aging parents. They are asked to call upon the aging family in order to identify supportive services for the Alzheimer victim. It is very difficult to explain to a client that this agency does have the expertise to link the family to available services but does not have the funding which would allow travel for the professional to visit the home because travel is not an allowable cost under title III-B of the act.

Another example is this agency has recently developed an interdisciplinary team approach to health care by creating an onsite health clinic for the elderly. This clinic has been designed with the coordination of Roger Williams General Hospital staff, the Southeastern New England Long-Term Care Gerontology Center, the Visiting Nurse Association of Providence, Cranston, Johnston, and North Providence, and the North Providence Senior Citizens Center, Inc. This combined effort provides a weekly health clinic for older persons who are without primary care physicians. In order to operate this clinic properly, medical supplies are needed which should be an allowable cost under title III-B of the act.

The State of Rhode Island for fiscal year 1984 is receiving less in title III-B funding than received during fiscal year 1981 and is trying to provide additional services to many more people. During the last year, approximately 43,000 persons were serviced across all programs and 50 percent representing persons of greatest economic need.

I thank you, and I would like to take this time again to say it is an honor for the North Providence Senior Citizens Center to be chosen the site of this hearing.

[The prepared statement of Mrs. Russo follows:]

TESTIMONY OF
CORINNE CALISE RUSSO

Senator Pell, Committee Members, and Honored Guests.

My name is Corinne Calise Russo, Director of the North Providence Senior Citizens' Center, Inc. the focal point on aging in the Town of North Providence.

I am honored to have been given this opportunity to present testimony relating to the re-authorization of the Older Americans Act of 1965.

Since its initial enactment in 1965, the Older Americans Act has provided the inspiration and impetus for the development of a network of planners and service providers which reaches throughout our society. Through this network, thousands of elderly in Rhode Island have been served directly and thousands more benefit from advocacy and awareness - raising efforts. The broad, positive purposes of the Act have led to the delivery of vital services in a fashion which is both acceptable and accessible to our elderly.

As we approach the reauthorization process, my colleagues and other professionals, who are involved in the senior center movement, urge you, who are involved in that process, to examine the unique and positive aspects of programs developed under the Older Americans Act and to keep these aspects in mind as we seek to make necessary changes in the Act while preserving its special qualities.

Because I feel you are well aware of the demographic trends of our aging population and what this population will look like in the next ten years, I feel it is unnecessary, at this time, to review the figures. As a framework for policy, however, one should recognize that within the growth of the older population there tends to be a rapid rate of increase among the portion of the older population that is 75 years of age or older and the disproportionately large number of women within the older cohort, a trend that becomes more pronounced with increasing age.

In examining this portion of the aging population and realizing that as persons become older they tend to become more frail, it is important to retain all the services identified in Sec. 321.(a) of the Act. I have attached a list of these services to your copy of this testimony.

Because it has become clear that the regulations do not clarify or carry out the intent of Congress, it is necessary to consider adding explicit language to the statute to ensure that the purposes of the Act are implimented.

My colleagues, including the National Institute of Senior Centers, feel that numerous questions regarding Congressional intent can be answered by expanding and clarifying that part of Title III which contains definitions. Some terms commonly used are not currently defined in the Act. It would be helpful to include the definitions of such terms as "state unit on aging" and "the aging network" in the Act. (See Attachments) Of greater importance, terms such as "multi-purpose senior centers" and "community focal points for service delivery" which are currently defined elsewhere in the Act, should be included in Title III, Definitions, Sec. 302. in order that Title III and its corresponding regulations are consistent in their language.

The definition of "multi-purpose senior centers" currently in Sec. 321(b)(1) of the Act and Sec. 1321.3 of the March 31, 1980 regulations adequately describes what senior centers are, and that language should be retained.

A revised definition of community focal point for service delivery as recommended by the National Council on the Aging, Inc. and acceptable to professionals in Rhode Island is as follows:

> "A facility or mobile unit within a defined community which provides older persons with maximum direct access to available services, in a fashion acceptable to them,

by encouraging co-location and coordination of services for older individuals. Community focal points for service delivery shall be designated by the state or area agency, which shall give special considerations to designating multi-purpose senior centers as such focal points."

Following the March 31, 1980 regulations, the State of Rhode Island developed an in-depth screening tool in order to identify and designate community focal points on aging in a fair and equitable manner. Because of this, it is important that the concept of community focal points for service delivery be retained in the Act. Given the increased recognition of the importance of having the most comfortable entry point to services for our aging population, community focal points play a critical role in providing necessary accessibility while reducing the likelihood of fragmentation and unnecessary duplication of services. Of major importance is having a professional agency whose staff has the knowledge of linking the client to the respective service thereby reducing time and costs in identifying the necessary service for the older person.

Because of conflicting interpretations, the language of other sections of the Act should be modified to clarify what the original Congressional intent was.

Section 321.(a) identifies many necessary and needed supportive services for which the Commissioner shall make grants to the States in order for these services to become available to the elderly. However, in Sec. 321.(b)(2) the Act states that "funds made available to a State under this part may be used, for the purpose of assisting in the operation of multi-purpose senior centers, to meet all or part of the costs of compensating professional and technical personnel required for the operation of multi-purpose senior centers." This section should be revised to make it clear that funds allocated may be used for all legitimate operational costs to a multi-purpose senior center. If the multi-purpose senior center is the vehicle for the delivery of services listed in this section, it is imperative that funding not be so restrictive. Along with personnel costs, other costs such as equipment, supplies, utilities and travel should be allowed.

To support this view, I would like to site a few examples of why flexible funding should be allowed.

The staff of this agency is constantly called upon by children of aging parents. They are asked to call upon the aging family in order to identify supportive services for the Alzheimer's victim. It is very difficult to explain to a client that this agency does have the expertise to link the family to available services but does not have the funding which would allow travel for the professional to visit the home because travel is not an allowable cost under Title III-B of the Act.

Another example is this agency has recently developed an interdisciplinary team approach to Health Care by creating an on-sight health clinic for the elderly. This clinic has been designed with the coordination of Roger Williams General Hospital Staff, The Southeastern New England Long Term Care Gerontology Center, The Visiting Nurse Association of Providence, Cranston, Johnston, North Providence and The North Providence Senior Citizens' Center, Inc. This combined effort provides a weekly health clinic for older persons who are without primary care physicians. In order to operate this clinic properly, medical supplies are needed which should be an allowable cost under Title III-B of the Act.

It is important to recognize that Title III-C (Nutrition) has received increases in funding during recent years. This funding increase has created an increased number of persons being serviced by home delivered meals and congregate meals. In order for the other social services to maintain their current level and provide for the new people being serviced, it is important that Title III-B funding be increased. We must recognize that the meals program is only one of the programs housed within the multi-purpose senior center.

The State of Rhode Island, for fiscal year 1984, is receiving less in Title III-B funding than received during fiscal year 1981 and is trying to provide additional services to many more people. During the last year approximately 43,000 persons were serviced across all programs and 50% representing persons of greatest economic need.

I hope that my testimony here today has been of help to the committee and I wish to extend to the committee any assistance requested of me at any future date.

Furthermore, I would like to take this time to say that it is an honor for the North Providence Senior Citizens' Center, Inc. to be chosen the site of this hearing.

1555.

Part B—Supportive Services and Senior Centers

PROGRAM AUTHORIZED

Sec. 321. (a) The Commissioner shall carry out a program for making grants to States under State plans approved under section 307 for any of the following supportive services:

(1) health, education and training, welfare, informational, recreational, homemaker, counseling, or referral services;

(2) transportation services to facilitate access to supportive services or nutrition services, or both;

(3) services designed to encourage and assist older individuals to use the facilities and services available to them;

(4) services designed (A) to assist older individuals to obtain adequate housing, including residential repair and renovation projects designed to enable older individuals to maintain their homes in conformity with minimum housing standards; (B) to adapt homes to meet the needs of older individuals suffering from physical disabilities; or (C) to prevent unlawful entry into residences of elderly individuals, through the installation of security devices and through structural modifications or alterations of such residences;

(5) services designed to assist older individuals in avoiding institutionalization, including preinstitution evaluation and screening and home health services, homemaker services, shopping services, escort services, reader services, letter writing services, and other similar services designed to assist such individuals to continue living independently in a home environment;

(6) services designed to provide legal services and other counseling services and assistance, including tax counseling and assistance and financial counseling, to older individuals;

(7) services designed to enable older individuals to attain and maintain physical and mental well-being through programs of regular physical activity and exercise;

(8) services designed to provide health screening to detect or prevent illness,[1] or both, that occur most frequently in older individuals;

(9) services designed to provide preretirement and second career counseling for older individuals;

(10) services of an ombudsman at the State level to receive, investigate, and act on complaints by older individuals who are residents of long-term care facilities and to advocate the well-being of such individuals;

(11) services which are designed to meet the unique needs of older individuals who are disabled;

(12) services to encourage the employment of older workers, including job counseling and, where appropriate, job development, referral, and placement;

(13) crime prevention services and victim assistance programs for older individuals;

(14) a program, to be known as "Senior Opportunities and Services", designed to identify and meet the needs of older, poor individuals 60 years of age or older in one or more of the following areas: (A) development and provision of new volunteer services; (B) effective referral to existing health, employment, housing, legal, consumer, transportation, and other services; (C) stimulation and creation of additional services and programs to remedy gaps and deficiencies in presently existing services and programs; and (D) such other services as the Commissioner may determine are necessary or especially appropriate to meet the needs of the older poor and to assure them greater self-sufficiency; or

(15) any other services;

if such services meet standards prescribed by the Commissioner and are necessary for the general welfare of older individuals.

APPENDIX

The following two acceptable definitions for the aging network and state unit on aging are taken from the National Association of State Units on Aging's An Orientation to the Older Americans Act--May 1982.

aging network -	A highly complex and differentiated system of federal and state and local agencies, organizations, and institutions which are responsible for serving and/or representing the needs of older people. The network is variously involved in service systems development, advocacy, planning, research, coordination, policy development, training and education, administration and direct service provision. The core structures in the network include the Administration on Aging (AoA), 57 State Units on Aging (SUAs), some 665 Area Agencies on Aging (AAAs) and numerous service provider agencies.
State Unit on Aging -	An agency of state government designated by the governor and state legislature as the focal point for all matters related to the needs of older persons within the state. Currently, there are 57 State Units on Aging located in the 50 states, the District of Columbia, and the U.S. Territories.

Senator **Pell**. Thank you very much indeed, Mrs. Russo. Now we will hear from Mrs. Ann Hill.

STATEMENT OF ANN D. HILL, DIRECTOR OF ST. MARTIN dePORRES MULTISERVICE CENTER, PROVIDENCE, RI

Mrs. **Hill**. Thank you, Senator Pell. Today I'll be wearing four hats. I'm the director of the St. Martin dePorres Senior Center, serving the largest number of minorities in the State. I am a member of the National Center and Caucus on Black Aged. I am representing the Rhode Island Chapter on Black Aged. And I am a black aged.

A Senate report issued in 1971 examined what it means to be old, poor, and black in America. The conclusion was, "The majority of blacks over 65 have less income, are less educated, suffer more illness, have poorer quality of housing; and, in general, have a less satisfying quality of life."

In 1974 a survey conducted to determine the needs of the black elderly concluded their major difficulties were, on a national level: One, income; two, health; three, crime; four, nutrition and transportation were tied; and, six, housing.

In 1982 a survey conducted among the black elderly in Rhode Island cited the needs as income, health care, transportation, in-home/chore services, nutrition, crime, and employment.

Clearly in the 11-year span the needs have not lessened. It is interesting to note that although the Older Americans Act has been in place for almost 20 years, the majority of difficulties cited by the black aged remain the same.

As difficult and painful as it is for many to accept, the root cause is the inability or the refusal to serve people not based on race, creed, or color. Negative attitudes have actually led to the denial of services to the black elderly. The stereotyping of blacks is still very strong and very influential. If practitioners are not aware of the facts and sensitive to stereotyping, then it seriously impairs their ability to deal with blacks and other minorities. The worker who says, "I cannot get blacks to participate in my program or in our agency," has already created a prejudicial attitude to eliminate the black population. Perhaps this practitioner should look at the staffing patterns of their agency.

Elderly blacks have learned from a lifetime of experience that a high level of service should not be expected from public agencies. This is a consequence of a painful history of inequality, rejection, and ejection. Blacks have had little or no influence on most programs and services for the aged. Generally, no one bothers to ask older blacks about their needs so there is no real sense of involvement in the programs addressed to the elderly. When the black elderly have been asked for input, the suggestions are rarely adhered to or implemented.

The question then becomes are the black elderly being adequately served through the Older Americans Act? My answer is the Older Americans Act is the greatest piece of legislation to come down the pike to provide services to the older people. But let's look at a couple of examples.

The phrase "greatest economic and social need" has created more hostility than the first voting rights act. Yet the law clearly states that minorities, blacks, Hispanics, physically and mentally disabled, limited-English-speaking, are among the target populations to be served. And I am talking about from a national level now. Throughout the country, this has caused tremendous battles and, in my opinion, unnecessary hostilities which in some cases will never be overcome. My question is, Why? Certainly this does not mean that this population would be the sole benefactors of these funds. It clearly states that grants should be awarded in proportion to the numbers in the State. This is not happening anywhere in the State. It has, however, brought out some very interesting attitudes toward this target population.

Funds for multipurpose senior centers have consistently been cut. Yet it is the senior centers that would provide services to the largest number of this target population. The senior center was recommended via the Older Americans Act to be identified as a focal point. Yet in checking around, the community centers that serve the large number of minorities have not been so designated. In fact, we could only find 3 centers out of 4,600 in the United States that are serving minorities that have been designated as a focal point. This clearly left the blacks and other minorities in a hit-or-miss situation where services are concerned. And at a recent meeting with many black providers, it made those of us who are providers assume that it is felt we are not even legislatively capable to be so designated even though we may fit the criteria.

Training programs have been cut or stopped almost completely. Yet the purpose was to, and I quote from the act, "To attract a larger number of qualified persons into the field of aging," and, "To help trained personnel become more responsive to the needs of the elderly." I would assume this would be inclusive of the black population.

Employment opportunities have not been very prevalent for the black elderly. The system is so devised that many would lose other life-support benefits such as food stamps or medical assistance in their own homes where expenses far outweigh their incomes.

The Older Americans Act, I repeat, is one of the greatest pieces of legislation to benefit older Americans. However, many historical attitudes have produced an unfair system that has kept blacks on the periphery of many benefits. The present administration in Washington is not helping the situation nationally.

The more money that is cut from the budget, the fewer minorities that are served. Perhaps that's the name of the game. But as an aide of Chairman Pete Domenici said, and he is a Republican, by the way, "Trying to reduce the deficit through cutbacks in social programs is like trying to move an elephant by the tail." Only 7 percent of the total budget is spent on social programs.

I would hope that this Congress would look at where our money is going and the value of our older people here in America and would begin this year to make a decided change that we too will begin to respect our elderly. I would hope that they would be looked upon and we would be looked upon as a homogeneous group of people having a variety of needs but coming together under the aegis of aging. Just because a person is 70, it does not mean that they fit into everything. And I think we've tried, and it's been mentioned here, that what's good for one is good for all. And this is not necessarily true, and if we look around the State, I charge you to look around the State, travel across the country, and, Senator Pell, you made a comment which I would like to use, misery is invisible. And few people have known the misery that I've suffered in the 24 years that I've worked with the black aged.

Senator Pell, you also might be interested in knowing that in our senior center, and I don't think that we would be very different than most senior centers, it costs us about $4 a year, excluding the nutrition program, to keep an older person active in the senior center. It costs over $65 a day to keep them in a nursing home. And I ask you why is it so difficult for our American Government to look at preventive measures rather than looking at things after they've happened?

I see the Older Americans Act as a tremendous preventive program which should not be diffused but should be infused with many, many dollars that we're wasting on light bulbs and other unessentials.

In closing, I would say this. Unjust conditions do violence to individual human dignity. It erodes the Nation's domestic peace. Homelessness violates the peace. Joblessness violates the peace. Hunger violates the peace. In doing this, we are violating the rights of Americans. Thank you.

[The prepared statement of Mrs. Hill follows:]

Senior Citizens
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PROVIDENCE, RHODE ISLAND 02907
274-6783

REV. ROGER M. FORTIN
ADMINISTRATOR

ANN D. HILL
DIRECTOR

RE-AUTHORIZATION OF THE OLDER AMERICANS ACT AND THE BLACK ELDERLY

Public Hearing, January 17, 1984-Senator Pell

Ann D. Hill, Director, St. Martin dePorres Senior Center

In the United States, we have certain democratic ideals about access to services, availability of resources and social support. We believe there should be equal opportunity for the goods of society. Yet in reality, we know that elderly people, particularly black elderly people, are very deprived with regard to access, availability and support. A Senate report issued in 1971 examined what it means to be old, poor and Black in America. The conclusion was "the majority of Black over 65 have less income, are less educated, suffer more illness, have poorer quality of housing; and, in general, have a less satisfying quality of life."

In 1974, a survey conducted to determine the needs of the Black Elderly concluded their major difficulties were 1)income, 2)health, 3)crime, 4)nutrition and transportation were tied and 6)housing.

In 1982, a survey conducted among the Black elderly in Rhode Island cited the needs as 1)income, 2)health care, 3)transportation, 4)in-home/chore services, 5)nutrition, 6)crime and 7)employment.

It is interesting to note that although the Older Americans Act has been in place for almost twenty years, the major difficulties have remained the same. The number of Black Elderly served has been dramatically increased.

As difficult and painful as it is for many to accept, the root cause is discrimination. Negative attitudes have actually led to the denial of services to the Black Elderly. The stereotyping of Blacks is still very strong and very influential. If practitioners are not aware of the facts and sensitive to stereotyping, they will operate in a mind set which will seriously impair their ability to work with Black Elderly. The worker who says "we can't get Blacks to participate" or "Blacks are not interested in our Agency's programs" has already created a prejudicial attitude to eliminate Blacks. Perhaps, this practitioner should

MEMBER: CATHOLIC CHARITY FUND APPEAL
NATIONAL COUNCIL ON THE AGING, INC.
NATIONAL INSTITUTE OF SENIOR CENTERS
COUNCIL OF COMMUNITY SERVICES
NATIONAL CAUCAS ON THE BLACK AGED

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look at the staffing pattern of their agency.

Elderly Blacks have learned, from a life time of experience, that a high level of service should not be expected from public agencies. This is a consequence of a painful history of inequality, rejection and ejection. Blacks have had little or no influence on most programs and services for the aged. Generally, no one has bothered to ask older Blacks about their needs so there is no real sense of involvement in the programs addressed to the elderly. When the Black elderly have been asked for input, the suggestions are rarely adhered to or implemented.

The question then becomes are the Black Elderly being adequately served through the Older Americans Act?

1. The phrase "greatest economic and social need" has created more hostility than the first voting rights act. Yet, the law clearly states that minorities...Blacks, Hispanics, physical/mentally disabled, limited English speaking are among the target populations to be served. Throughout this country, this has caused tremendous battles, and, in my opinion, unnecessary hostilities which may never be overcome. My question is why? Certainly, this does not mean that this population would be the sole benefactors of these funds. It clearly states that grants should be awarded in proportion to their numbers in the state. This is not happening anywhere in the country. It has, however, brought out some very interesting attitudes toward this "target" population.

2. Funds for Multi-purpose Senior Centers have consistently been cut. Yet, it is the Senior Centers that would provide services to the largest number of the target populations. The Senior Center was recommended via the Older Americans Act to be identified as a "focal point". Yet, in checking around, centers that serve large populations of minorities have not been so designated. This clearly left Blacks and other minorities in a hit or miss situation where services are concerned. It has further made those of us who are providers to assume that it is felt we are not intellectually capable to be so designated even though we more that fit the criteria.

3. Training programs have been cut or stopped almost completely. Yet, the purpose was to and I quote "to attract a greater number of qualified persons into the field of Aging" and "to help trained personnel become more responsive to the needs of the elderly." I would assume this would be inclusive of Blacks and minorities.

4. Employment opportunities have not been very prevalent for the Black elderly. The system is so devised that many would lose other life support benefits as food stamps or

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medical assistance. This is especially true for persons living in their own homes where expenses far outweigh their incomes.

The Older Americans Act is one of the greatest pieces of legislation to benefit older Americans. However, many historical attitudes and an unfair system has kept the Blacks on the peripheral of the benefits.

The Blacks and others are the victims of years of discrimination. Because discrimination is a way of life, it still goes unnoticed by some and very painful to others.

The more money that is cut from the budget, fewer minorities will be served. Perhaps, that's the name of the game. But as an aide of Chairman Pete Domenici said, "trying to reduce the deficit through cutbacks in social programs is like trying to move an elephant by the tail." Only 7% of the total budget is spent on social programs.

I would hope that this Congress would look at the population of elderly as a homogeneous group sharing many commonalities but having a variety of needs.

Senator PELL. Thank you, Mrs. Hill, for singularly moving and eloquent testimony shown by the fact that the applause you received, I think I can honestly say, was more than anybody else received. I too am much moved by what you say. I agree with you that preventive medicine is what we should be much more engaged in. I like the old Chinese idea that you pay the doctor while you are well on a monthly basis; but if you get sick, your payments stop until you are well again. And if you have the misfortune to be the doctor to the Emperor, if he died you were beheaded. That caused very good preventive medicine. And I share that thought.

Now, I would like to bring the focus down to Rhode Island for a moment and ask you here if you think that in that blacks and minorities have as equal access to senior centers and the Older Americans Act as others do.

Mrs. HILL. I think that here in Rhode Island the answer is, yes, they do. They can go. The problem we have in Rhode Island is that we do not demonstrate among our staffing patterns the willingness to be cordial, shall I say, inviting. In our agency, for example, we serve, according to our December 31 figures, so far about 896 black elderly, but at the same time we also served over 700 white elderly. My staff represents that. I provide blacks and white, French, Italian. All are on the staff. So that I'm saying to the older person, "You're welcome here." And I think we have to look at that. This has been a historical thing that I talked about. I think we have to look at if we really want to serve, and, you know, I made the statement some time ago that I would never be made director of the Jewish Community Center. I believe that. Any more than I would be made director of Federal Hill House. I wouldn't even apply. There are certain cultural and language differences that exist even though I could very well relate to people of Italian descent. We have them in our center.

But I think we have to put our mouth where our money is or our money where our mouth is or whichever way that goes and say that, "Yes, I really, truly want to serve the population in Rhode Island; and, therefore, I am going to utilize whatever resources there are to do this." And I think the staffing patterns are crucial.

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Senator Pell. Do you think that when it comes to getting jobs under the title V, Senior Community Service Program that—do blacks have an equal opportunity there?

Mrs. Hill. We have very few who are employed through that program, but I am not really sure, because my agency has been contacted to provide people. The problem we have, Senator Pell, is that many of the people we work with receive medicaid and other benefits. The program would eliminate them from their life-support benefits, yet— in fact, I have got a person who is going to be terminated from the title V program because with an increase in her check she has $17 too much, a person who has been with us for quite a while. In fact, without an increase, we are going to be terminating about four senior citizens employed at St. Martin's right now this year. So it isn't a question of whether the blacks get the jobs or not. It is a question of whether the regulations are fair and whether the regulations are just to be inclusive of the black community.

Senator Pell. Thank you really for a very eloquent statement and the way you replied. Now, Mrs. Russo, you suggested that the cost for equipment, supplies, and travel should be covered by the act. How do you raise that money now?

Mrs. Russo. Right now, Senator, in our community we are very fortunate because we are able to get a local match from the taxpayers and in the town budget. Our concern is that in many communities that is not an opportunity that's available to all senior centers. This is how we presently get our match.

Senator Pell. What do you think you could do so that there would be an increasing number of older people coming to your center?

Mrs. Russo. We're very happy with the numbers of people who presently come to the center. And I think that to attract more people to the center would just mean that we would have to add different types of programs that would be conducive to the needs of that particular individual. So that you need to be able to offer programs at every level because you are servicing a peer group that ranges from age 55 to 100.

Senator Pell. Right. To 100, I am glad to hear that. Thank you very much indeed, Mrs. Russo, Mrs. Hill, for being with us today.

I would add here that in connection with the previous panel on senior nutrition, that Mr. Joseph Brown, the director of the statewide Meals on Wheels Program, was not able to appear on the platform today because of the press of time but has submitted very valuable testimony that will be examined in full by the subcommittee.

Our final panel are concerned with senior services in the next decade, and we are very honored to have Dr. Donald Spence, director of the URI Gerontology Program; and Dr. Gamal Zaki, director of the Rhode Island College Gerontology Program with us today.

Dr. Spence, I had the good fortune to hear on the radio program because he and I shared one, although we were in different parts of the State at the same time.

Dr. Spence. Yes; I enjoyed that very much.

Senator Pell. And I hope your telephone system worked better than ours did.

Dr. **Spence.** We were in the studio. So ours was fine. I listened to your difficulties.

Senator **Pell.** I am very interested in the subject of gerontology, and I think that is a fitting final panel because you will be looking at senior services in the next decade and where we go from here.

STATEMENT OF DR. DONALD L. SPENCE, PROFESSOR AND DIRECTOR, PROGRAM IN GERONTOLOGY, UNIVERSITY OF RHODE ISLAND

Dr. **Spence.** I want to thank you and David for inviting me to make this presentation, and I will try to summarize my arguments as briefly as I can, given the shortness of the time involved.

I'm another one of those people whose professional career spans the development of the Older Americans Act. Actually, my career in gerontology began in 1960. So the 23 years that you mentioned parallels my own involvement in aging research and training.

I am primarily an educator and scholar; and as a consequence, I am going to make some recommendations specifically to title IV of the Older Americans Act; but the argument to support that is, I think, very critical because the present administration has chosen to cut at title IV and in a sense pit the discretionary components of the Older Americans Act against some of the direct service components of the Older Americans Act.

I think that the discretionary elements within the Older Americans Act are one of its real strengths and reflect the wisdom of Congress in the original development of this program. I have said a number of times that we are pioneering—the older people of this State and of our Nation are pioneering a totally new life period. I mean there has never been, there is no historical precedent for what's happening. And as a consequence of that, we need the flexibility that is given by title IV of the Older Americans Act to be able to develop research in the social area and to introduce demonstration programs which assure us of the effective operations of service delivery to all older citizens.

I think the classic example is in the home health care field where, you know, we are the only advanced industrial nation in the world that still delivers health care through an entrepreneurial system. If you take resources away from a major segment of its population like we do from the elderly, you have got to be able to do something other than sell them health care services on a cost basis or on a profit motive kind of basis. I think that's just one of the major areas that reflect the need to do research and to look at developmental issues in relation to programming in long-term care.

I think the other point that is essential, and I have heard several people up here talk about the needs for training and the needs to support the development of service providers in relation to the concerns of older people. I think one of the things that we've sometimes failed to realize is that an investment in higher education becomes then a resource that is with us that continues with us after that investment is made.

The current administration, in terms of favoring free enterprise, has supported a lot of education and training programs through entrepreneurs who, once they provide the training, are no longer available then to continue in that area, and that resource disappears. But if you make an investment in higher education, we then develop a resource which stays with us and which is available to us to support the aging programs that we have in our country.

Let me just briefly state six points which I think are important in terms of the reauthorization of the Older Americans Act, and then I will turn the mike over to Dr. Zaki.

Senator PELL. I would add that your statement will be inserted in full in the record for us to study.

Dr. SPENCE. Thank you. I agree with those who have said, "I think the Older Americans Act programs should be extended for at least 3 years in the reauthorization." There should be basically a simple reauthorization with only fine tuning changes, because the Older Americans Act has served our Nation well over the years. However, there is some need to strengthen the language, and I've heard it mentioned also by other people to make more specific the applications of the various titles in the Older Americans Act and to clarify the language.

Three, we need funding for title IV. It should be raised to more adequate levels. The reauthorization levels should partially recoup the sharp reduction in funding which occurred in recent years, and we should appropriately weigh projected inflation as well as future demands for aging research, training, and demonstrations.

Four, title IV should be deconsolidated and separate program categories should be restored. In addition, the scope and purpose of each program should be spelled out clearly and specifically, with emphasis upon certain targeted activities. The role of title IV should be clarified with respect to the service titles of the Older Americans Act.

Senator PELL. It shouldn't be seen as separate?

Dr. SPENCE. It should be seen as complementary to those service titles.

Five, title IV discretionary funds should not be comingled with other Office of Human Development Services funds or any other programs. Title IV appropriations should be used specifically for identifiable aging-related activities. The present administration has lumped these funds together, and as a consequence I think our older citizens are losing out on the applications of Older American Act funding.

And, six, the reporting provisions under title IV should be strengthened. AOA should submit a detailed annual report to Congress describing title IV activities, products, and plans. Thank you.

[The prepared statement of Dr. Spence follows:]

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I speak as a professional whose career in gerontology spans the same historical period as the Older Americans Act. I began working on aging related research in 1960 and took my first full time position in aging with the Geriatrics Research Program at the Langley Porter Neuropsychiatric Institute in San Francisco in 1965, the year the Act was implemented. I was a formal observer at both the 1971 and 1981 White House Conferences on Aging and have authorized proposals and directed programs funded under Titles III and IV of the Older Americans Act totalling over $2 million. I have witnessed advances in aging nutrition through the meals programs of the Older Americans Act, the development of employment opportunities for those without adequate incomes, the improvement of social opportunities and quality of life through support of senior center programming and the demonstration of model service programs to impact the lives of those with long term chronic health problems.

Primarily, however, I am a scholar and an educator and will speak to the issues of Title IV of the Act, research, education and training, and service demonstrations. The provisions of the Act and its discretionary mandate provide the Administration on Aging with the unique ability to set program direction in response to studied needs, educate and train the manpower necessary to address these needs, and then implement through model demonstrations services to improve the quality of life of every older American. The act is both general enough to provide support for all older Americans, with specific provisions to address the needs of those whose problems are more than they can bear alone. It was the wisdom of Congress which mandated this developmental approach to a service support system for older Americans recognizing the fact that we were pioneering an era of social life for which there is no historical precedent.

It is short-sighted of the present administration to think that money can be saved by cutting Title IV support. They attempt to argue, in time of economic constraint, that we must maintain direct services at the expense of education, training and research. This is the same falacy as the philosophy of American business when its concerns for short term profits fail to allow for adequate long range development. We are nowhere near having the social structure that would adequately allow older people to effectively meet their needs. One look at the cost of chronic health care based on a medical model designed for acute care medial intervention should make the point.

Services which are delivered without properly trained personnel, without a well tested and proven program design, and without benefit of a knowledge base which attests to their appropriateness and vitality are a waste of scarce resources. Even more to the point, poorly trained, insensitive and ill-informed personnel can do damage to the service delivery system and the elderly recipients of such services. It must be remembered that it is not just the service programs specifically designated under the Older Americans Act which serve the needs of older people. Private citizens in interpersonal relationships as well as the full gamut of professional service programs touch the lives of older Americans.

This is why it is so important for Congress to maintain a federal commitment to those programs which build the capacity of our educational institutions, both private and public, to provide on-going sustained service to the nation in the understanding, preparation and support of an effective third age.

I am not arguing for discretionary programs in lieu of direct service programs. I am arguing that both are mutually supportive, both are needed. All components of the Older Americans Act, if given the structural and financial opportunities, can cooperate in our common goal of improving the quality of life of older Americans.

What I would like to do in the time remaining is present six (6) general principles for the 1984 reauthorization of the Older Americans Act. In my written testimony I will expand on those principles that relate to Title IV with specific provisions for their implementation.

SIX GENERAL PRINCIPLES

1. Three-Year Reauthorization: All Older Americans Act programs should be extended for at least three years, through FY 1987.

2. Simple Reauthorization but Corrective Changes for Title IV: There should be essentially a simple reauthorization with only "fine tuning" changes, because the Older Americans Act has served our nation well over the years. However, strengthening language is necessary for Title IV research, training, and demonstrations to clarify the scope and purpose of these programs.

3. Increased Authorization Levels: Funding for Title IV should be raised to more adequate levels. Reauthorization ceiling should partially recoup the sharp reduction in funding (59% from FY 1980 to FY 1984) in

recent years and appropriately weigh projected inflation as well as future demandsfor aging research, training, and demonstrations.

4. De-consolidate Title IV: Title IV should be de-consolidated and separate program categories (e.g. researchm education and training, service demonstrations) should be restored. In addition, the scope and purpose of each program should be spelled out clearly and specifically with emphasis upon certain targeted activities. The role of Title IV should be clarified with respect to the service titles of the Older Americans Act.

5. Prohibit Commingling of Title IV Funds: Title IV discretionary funds should not be commingled with other Office of Human Development Services funds or any other programs. Title IV appropriations should be used specifically for identifiable aging-related activities.

6. Improved Reporting Requirements: The reporting provisions under Title IV should be strengthened. In addition, AoA should submit a detailed annual report to Congress describing Title IV activities, products, and plans.

SPECIFIC PROVISIONS TO IMPLEMENT THE GENERAL PRINCIPLES (TITLE IV)

A. Education and Training

1. Add a statement of purpose: A general purpose statement should be included in Title IV to clarify the overall role of Title IV programs and particularly to:

(a) Clarify Title IV's role concerning Title III. Title IV operates as a complement to Title III service delivery programs rather than as an independent or free-standing training and research program.

(b) Clarify Title IV's role relating to the Title V Senior Community Service Employment Program (SCSEP). Title IV provides education and training for personnel preparing for employment or already employed in the field of aging. Training under Title V is geared toward moving low-income older persons into unsubsidized employment. The Commissioner has chosen to interpret career preparation as an opportunity to channel training money into programs designed to enable older persons to continue employment and I believe that this is a Misinterpretation of the intent of Congress.

(c) Distinguish between education and training functions. Title IV training programs are directed as short-term in-service training and continuing education for personnel in the field of aging. Title IV education programs provide long-term instruction to prepare people for careers in the field of aging.

(d) Emphasize a dual commitment to quality (with emphasis on "best practices", uniformity, and building on acquired knowledge) and to innovation (new models and approaches). This commitment should be expressed for other Title IV programs as well.

(e) Attract qualified persons to the field of aging.

2. Training programs for personnel in the field of aging: There should be a specific provision spelling out the components and goals of training and education programs. Long-term training and educational goals should be emphasized. There should be a recognition of the role that academic institutions play as a national resource for providing education, training and research in the field of aging.

A provision to stress the need to train minorities (along the lines of section 404 (a) (6) in the 1978 Older Americans Act Amendments) should be included in Title IV (Cranston amendment).

B. Research

1. Add a statement of purpose: A general purpose statement should be included to specify long-term research goals for the Administration on Aging. This purpose statement should emphasize that Title IV funding is available both for "investigator-initiated" research and "directed" research from AoA. A commitment to both quality and innovation should also be stressed.

C. Demonstrations

1. Retain present Section 421: Section 421 should be retained, including the emphasis on certain target groups (e.g. serving the rural elderly and improving services for the minority and low-income aged). The cooperative roles played by academic institutions and service providers should be emphasized.

D. Special Project in Long-Term Care

1. A Center in every federal region: The current section 422 should be clarified to state that it is a goal to have an AoA-funded long-term care gerontology center in every federal region.

E. Utility and Home Heating Cost Demonstration Projects

1. Move to Title III: The present section 425 should be removed from Title IV. State and area agencies on aging should be given authority to carry out this activity, as deemed appropriate.

F. Multidisciplinary Centers of Gerontology

1. Specific language for National Policy Centers: Section 441 should make it clear that national policy centers are included within

"gerontological centers of special emphasis".

G. Budget Authorization

1. Authorization increase: Authorized funding under Title IV should be increased. The two proposals offered for consideration are modest given the level of funding achieved in 1980 (54.3 million):

Plan A - 5% Increase Per Year

Fiscal Year	Authorized Funding in Millions of Dollars
1984 (Current)	26.6
1985	27.9
1986	29.3
1987	30.8

Plan B - 10% Increase Per Year

Fiscal Year	Authorized Funding in Millions of Dollars
1984 (Current)	26.6
1985	29.3
1986	32.2
1987	35.4

2. Targeted authorizations: Separate authorizations should be included for the major sections of Title IV: education and training, research and demonstrations.

Senator **Pell.** Thank you very much, Dr. Spence. Now, Dr. Gamal Zaki, the director of Rhode Island College Gerontology Program. Dr. Zaki.

STATEMENT OF DR. GAMAL ZAKI, DIRECTOR OF RHODE ISLAND COLLEGE GERONTOLOGY PROGRAM

Dr. **Zaki.** I would like to make my comments very, very short and brief since we are running short of time.

I think I am going to address an issue which has not been adequately addressed, if it has been presented at all today, which is mental health in aging.

Recently we have been exploring the relationship between aging and mental health, and we are finding more or less that we have neglected this field for—almost except for the last three decades. And we are faced now with lots of phenomenon which we did not used to have before or at least interpretations and results of studies indicated that we are really addressing a very, very major problem, mental health in particular. I will just give you an example, one of which is Alzheimer's disease.

About 2 years ago we were contacted by the National Organization for Alzheimer's Disease at the center, and they said, "Can you start a chapter," and we were wondering who would come to us for help for Alzheimer's disease. We discovered that in the State of Rhode Island there are 10,000 cases of Alzheimer's. It is the fourth killer in the United States. There are 2½ million people afflicted with Alzheimer's disease in the Nation.

At this point there is no way we can diagnose it accurately. The only way we are sure it is Alzheimer's disease is after death through autopsy. And there is no cure up to this point, no cure whatsoever. There is nothing even we can do to stop the progression of the disease.

A group of families met together, and they started the national organization, and we picked it up. We have our own organization chapter in Rhode Island. We started—I am sure most of you heard about this—the Forum for Mental Health and Aging, in particular, and we discovered lots of problems which are not adequately addressed by the Older Americans Act or any other act. I am not concerned about the clients or patients right now. I am concerned about the families. I am concerned about the informal supportive system which we are having right now. There is nothing whatsoever done for the families who are really the care givers. It is not the nursing home, it is not the day care center. It is the family.

And, as you know, Senator Pell, when you asked people, they said, "We would like to stay with our families." What are we doing for the families that are taking care of our elderly? Zilch. Nothing. I will give you some examples, Senator, from our experience with patients and their families.

We have six support groups. We have 700 members coming to these support groups. Some of the rest of the 10,000, they don't want to come near us yet. But sometimes they bring the patients with them because nobody could come and babysit them. A recent case in California, a wife was charged with negligence which led her husband to die. He was an Alzheimer's patient. She didn't take care of him. He wandered, he fell down the stairs, and he died. They pressed charges against her because of negligence.

We are coming to a point now that taking care of the elderly is a major responsibility of our society, not through institutions, but through our agencies which have been providing this care since Adam and Eve started on Earth, the family. And we are doing nothing for them.

I will give you another example, Senator Pell, which might interest you. Nursing homes do not accept Alzheimer's disease patients. Day care centers do not accept Alzheimer's disease patients. We have just finished a national survey of all day care centers in the Nation. We found only 18 percent would accept minor cases of Alzheimer's disease. It is a very, very overtaxing job to take care of an Alzheimer's disease patient. It needs—there is a book, I am sure you all heard about it, "It Takes 36 Hours a Day." It takes a one-to-one relationship. We have no respite care to help the families to go on vacation or to go to work. No respite care.

I will give you an example of a case. A husband came to one of the support groups and he said, "Sometimes I feel that I would like to kill my wife because she is not my wife anymore. She is a different person. I am living with this guilt."

Relatives, they stop seeing the patients or seeing the families. We are not providing anything for them.

Let me give you another example, Senator Pell, of something which really irritates me. We are living in a society which I call the society of 9 to 5. We serve our elderly most of the time 9 to 5, and from 9 to the next day they are put on hold. Day care centers, for example, again, from our study we found out that 71 percent of the elderly who attend day care centers are living alone. And nobody cares during holidays or weekends or Christmas, what are they doing? There is no outreach work. They assume the responsibility only from 9 to 5. They don't understand that they have to assume the responsibility 24 hours a day. We have to deinstitutionalize our institutions. We have come to the point that elderly are people and they have needs 24 hours a day, not 9 to 5. More studies have been conducted in this area and prove the point.

You mentioned something. I am going to respond to one of the things, which is intergeneration education. How can we educate our children from the beginning? At Rhode Island College we are very proud to say we are working on that and we are developing a curriculum from kindergarten to 12 to teach children on aging. We have done studies on this, and it is very, very necessary.

There are some things which are happening in Congress, and I would like to announce them, and I am sure you are aware of them. One of which will be Congress and the President approved establishing AD centers around the country which would bring together experts from a variety of professions, each specializing in a particular aspect of the problem. Teams of scientists would work together under one roof. The centers would also be used to train health professionals in the latest techniques of care and treatment, and each center will have a special section devoted to community education.

I am requesting from you and begging you that one of the centers will be in Rhode Island. This has been approved already.

Congresswoman Olympia Snowe of Maine has already proposed three bills, they are in Congress now, whi[illegible]f passed, would help thousands of AD families. The first would [illegible]w families a tax deduction for expenses other than medical as[illegible]ated with providing home care for an AD patient. I wish it would apply in any elderly who is staying home and needs care, that every family would have tax deductions. The second would require the Veterans' Administration to begin a nationwide program of screening, counseling, treatment, and information programs on AD. In addition, the age of eligibility of any veteran suffering from AD would be lowered to 50. The third would give priority to Government grants for students to specialize in custodial or skilled care of Alzheimer's patients. And these have to be bonded and have professional insurance.

I am asking again, Senator Pell, please, give your support to these three bills because if they go through, then at least you are recognizing the most effective, the hard workers, parents, families, children, who are taking care of the elderly.

I am also proud to tell you that through our chapter we passed a bill in Rhode Island and we have a commission, legislative commission, to study Alzheimer's disease and related disorders, and we have been working very hard. Our report will be submitted to the legislature in April. As a consequence of this, it was accepted, establishing two wards in two hospitals, general hospitals, for intermediate and short-term respite care and also for Alzheimer's patients only. Thank you very much.

[The prepared statement of Dr. Zaki follows:]

SUMMARY

TESTIMONY REGARDING OLDER AMERICANS ACT

Dr. Gamal Zaki

INTRODUCTION:

This testimony will focus on some problems which are inadequately addressed by the Older Americans Act. These problems have recently increased to the point that immediate strong measures have to be taken to alleviate them and their consequences.

It is becoming evident that the area of mental health and aging has been grossly neglected in the past. The Rhode Island College Gerontology Center has taken the iniative and has held regional forums annually to probe the different aspects of this vital area. This testimony will summarize some of our findings.

DEMENTIA AND AGING:

During the last three decades, there has been increasing interest in studying the different types of dementia associated with aging. One is astounded by the many different types and overlap of symptoms. In actuality, some of them are difficult if not impossible to accurately diagnose; e.g., Alzheimer's disease.*

As a case in point, we will focus on this disease to explore what the Older Americans Act does or does not cover in terms of the elderly and their families. This is most appropriate, as there are an estimated 2.5 million cases of this disease in the United States alone.

MAIN PREMISES:

It is known that irreversible dementia cannot be cured. The damage is done, and in no way can be repaired. From the early stages of the development of dementia, we realize that the symptoms become noticeable not only to the victim, but to the immediate family as well. The results are usually devastating. NO CURE...NO HOPE... It becomes very difficult for the immediate family members to cope with the situation.

The existing philosophy of mental health is based primarily on deinstitutionalization. This process is aided by the use of medications and linkage with the community mental health system. Institutions are reluctant to accept chronic cases, especially those who are afflicted with senile dementia of the Alzheimer's type. Patients are most oftem kept at home, being cared for by family, with practically no formal support from the system. Essentially, there are many "one bed nursing homes" in existence across the country.

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*Alzheimer's disease is a progressive disorder of the brain affecting memory, thought and language. Changes occur in nerve cells in the outer layer of the brain producing almost imperceptible symptoms at first. As the disease progresses, simple forgetfulness increases to more noticeable memory loss and other changes in thought, personality and behavior which can render the victim incapable of taking care of self and communicating needs to others. As the population ages, the prevalence of Alzheimer's disease is expected to more than triple in the next fifty years.

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DEFINITION OF THE PROBLEM:

The following are some of the dimensions of the problem and their consequences:

A. SOCIAL STRESS:

From the early stages of the development of dementia, families and the victims are faced with isolation from the rest of their social milieu. It becomes an embarrassment to the families to socialize with relatives or friends due to the behavior of the demented person. This behavior is uninhibited, and the victim often acts without the usual social constraints.

The life-style of the family has to change to accomodate the needs of the Alzheimer's victim. The victim needs constant observation because behavior becomes unsafe and sometimes harmful to self and others. There is a likely possibility that the victim will wander off, and because of memory loss, will be unable to identify self or place of residence when found. The family must be protective; in several instances, the family may be held liable if the victim is neglected or harmed. The family is engaged in caring for the victim "36 hours a day".

The Alzheimer's victim is physically healthy, except for the brain deterioration, and is looked upon as "normal" by the casual observer. The illness is largely invisible, and therefore it is most difficult for family and friends to comprehend the memory and personality changes. Interaction is with "someone they once knew".

B. PSYCHOLOGICAL STRESS:

Family members experience considerable psychological duress. Grief is intense, and prolonged, as the victim slowly regresses. Anger is common, especially in reaction to the irritating behaviors of the victim, the lack of response from the formal health care system and the constraints placed on life-style. Families become exhausted. Guilt is often intense, related to ambivalence of feelings. Often a "death wish" is present to relieve all concerned. There have been some incidents of murder by family members in Texas and Florida.

C. ECONOMIC STRESS:

Long term care is inevitable for Alzheimer's disease victims who live long enough with the disease. Paying for this care is prohibitive, with very little support from the formal system. In order to qualify for Medicaid, families have to experience almost total depletion of their economic resources. This can be a particular hardship for those who are living on retirement income, with a bit of money saved as a back-up.

As a result, families tend to keep the Alzheimer's victim home for an extraordinary period of time. Within the community health care resources, available care is expensive and selective. Much needed care is not available, namely respite care. There is little if any assistance to families who use day care or home health aides.

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SERVICES:

Services available for Alzheimer's victims and their families are limited. Within the community system, those who are minimally affected can take part, on a limited basis, in senior citizen center programming. All too soon, however, this level of unsupervised activity becomes inappropriate. Day care is the next necessary level, however it is limited in its availability, and many day care centers do not accept Alzheimer's victims. Home care is available on a limited basis, but is costly (approximately $7.00/hour). Respite, either in overnight accomodations or in in-home respite care is nearly non-existent. There is no funding from public sources to provide this much-needed level of community-based service. Respite care, however, would serve to prevent premature institutionalization in many instances. Families could carry on much longer, given some back-up assistance that would provide some relief. Nursing homes are selective - many do not accept Alzheimer's victims. This is because of limited staffing and inadequate security. Families often have to either capitulate and place the victims earlier than necessary to ensure placement, or settle for a facility that is not desirable.

RECOMMENDATIONS:

Based on the above and all the many implications, the following is recommended

1. A careful assessment of the long-term care system, from senior centers to chronic care facilities, to determine the need for changes in policies that affect the funding and regulation of care.
2. Better coordination between administration of the Older Americans Act and the Social Security Act so that needy individuals do not "fall between the cracks".
3. Particular attention should be paid to the needs of Alzheimer's disease victims and their families, especially in that it is a widespread disorder that has very specific needs not yet being met.

Senator Pell. Dr. Zaki, I was very struck with your statement that 10,000 people, 1 percent of our population in Rhode Island, have Alzheimer's disease. Is this the result of studies of the people after they died, of autopsies, or how do you come to this conclusion if you can only tell after they are dead?

Dr. Zaki. This is the national figure. As it stands now the diagnostic process is by elimination. So they come, with the bulk of people, they must have Alzheimer's disease, that's the end of it. But nobody can really say this patient is afflicted except after autopsy. The 10,000 people——

Senator Pell. Ten percent of the American people today have Alzheimer's today?

Dr. Zaki. Rhode Island; 10,000.

Senator Pell. That would be the same nationally?

Dr. Zaki. We are higher because 13 percent of our population has it. We are higher than the average nationally because nationally it is 11 percent. Rhode Island in particular is, you know, 13 percent. So a little bit higher than the rest. But, amazingly, we don't know why this particular area, Rhode Island, is that high.

Senator Pell. Does this affect everybody, Asians, blacks, Caucasians, everybody about equally?

Dr. Zaki. Everybody. The only thing which we found out with females it is higher because females out live men 5 years. So it appears with females and stays longer. It is not particularly related to aging. It is called senile dementia of Alzheimer's type. It used to be premature senility. We have people here in Rhode Island 50 years old, 45 years old, who are afflicted with it. But the majority of people, when they get older, there is a chance. Why does it happen? Nobody knows if it is aluminum deposits, if it is because of heredity factors. Nobody knows at all. And only Congress approved recently, approved $25 million for research to find out what it's all about. It is the fourth killer in the Nation now.

Senator Pell. Thank you very much. Dr. Spence, in your statement you mentioned the importance of getting qualified people into the field of aging, and this is particularly important in our State whereas Dr. Zaki said we have a higher percentage of aging. What is being done to attract people into our faculty and into our departments at URI?

Dr. Spence. We have recently done a survey at the university, and we are now offering the equivalent of 8,000 credit hours a semester in terms of aging instruction, not specifically aging-related courses, but trying to permeate the total curriculum of the university as it relates to some 5 out of the 7 colleges where appropriate courses are offered that they include curricular issues relating to the elderly or the appropriate application of those professional areas.

Senator Pell. Would there be graduate degrees accorded in gerontology?

Dr. Spence. Even on a national level that's a very—we are looking at the development of some graduate programs which would include gerontological specializations. For example, in the nursing field we have a master's degree now which has just included specialization for gerontological nursing, and we are developing a proposal for a Ph.D. in nursing which would include gerontology as one of the areas of specialization. The idea of a degree in gerontology is somewhat foreign because gerontology is a multidisciplinary field; and if you are talking about specialized training at the doctoral level or at the graduate level, you are usually talking about specialized training within a discipline like biology or within psychology or within the social sciences.

Senator PELL. Dr. Zaki.

Dr. ZAKI. I just want to add something. At Rhode Island College we have a certificate program in gerontology. It is supplemental to a major because gerontology doesn't have the skill base. So we have a nurse with gerontology, social worker with gerontology, and we are very, very happy and proud to say that the majority of people working in the field are coming to us now. Fifty-five percent of our students are practitioners. As a matter of fact, we are proud also—I see some of my students here who are directors of nursing centers. They are our students and our hospitals. We have most of the nursing graduates of our program. So we are trying to integrate this as much as we could. However, the problem is again financial because we do not have the ability to support these people to leave their jobs and come and to do the training they need.

Senator PELL. Thank you very much. I would add, Dr. Zaki, we will include in the record your full statement that we have here.

Dr. ZAKI. Thank you.

Senator PELL. Dr. Spence, one other question. And that is what areas of aging research should be explored more fully?

Dr. SPENCE. I think really my own interests are in terms of some of the organizational issues. For example, medical care in this country costs some 10 percent of our gross national product. There are other nations in the world where medical care is considerably less, their gross national product is less per capita, and yet on national standards they are delivering health services as effectively as we are. I think even the Health Care Financing Administration in its last announcement indicated an interest in looking at some reorganization with respect to the increased authority of nurses in relation to long-term care services. I think there is an appropriate relationship between medicine and long-term care, but I think what has happened is we've developed a long-term care system which is built upon a medical model which was designed for acute care intervention and is a very inappropriate model for most of the chronic health care problems faced by older people. We can make significant savings in terms of the delivery of service and improve the quality of care. We know, for example, that a lot of health care decisions in long-term care are made by other than physicians now. Physicians have to endorse it, but nurses make a lot of decisions that are made in long-term care.

Senator PELL. I thank you both very, very much indeed. I would add that this hearing is coming to a close. I think we have seen today how important the subject matter is for our State where one-quarter of our State population is over 55. We are dealing with one-quarter of our State's people. We have seen that more education is needed in health, particularly in the field of nutrition, that we may need a larger Federal role in long-term health care, although that would be difficult to produce with the present policies being followed now in Washington, and that senior centers and meal sites provide many services, but there are a lot of people they do not reach. And as Mrs. Hill so eloquently said, misery is invisible.

Our job is to try to find that invisible misery and to alleviate it to the best of our ability. I will take back to Washington the knowledge that we've picked up here today. I would thank again Peter Conroy representing Senator Grassley who has made possible this hearing and to David Neumeyer who has done an excellent job in setting it up. I also thank again Mrs. Russo for her hospitality, the use of this room. This concludes the hearing.

[Additional material supplied for the record follows:]

ELDERLY SERVICE NEEDS

PRESENTED BY
RUTH D. COOKE, R.N.

EXECUTIVE DIRECTOR

VISITING NURSE SERVICE OF GREATER WOONSOCKET

ON BEHALF OF

WOONSOCKET CONSORTIUM ON AGING

AND

TRI-HAB HOUSE, INC.

Honorable Senator Pell, Mrs. Tucker, Members of the Subcommittee on Aging, I am Ruth Cooke from Woonsocket. I am the Director of the Visiting Nurse Service of Greater Woonsocket and the chairman of the Woonsocket Consortium on Aging. I will speak briefly on two areas of need in our community which also are present in other parts of our state and nation—namely, elderly day care and alcoholism. These are not necessarily unrelated since more and more the isolated, lonely senior citizen is turning to alcohol and may remain undiscovered until some other emergency occurs.

At present third parties pay for detoxification, but no in-home services are allowed. In-home services prevent a continuation of the problem and could prevent future need for detoxification and/or hospitalization for complicating conditions (malnutrition/pneumonia) for which alcohol is the base.

In-home services could provide for early treatment of an alcohol problem before detoxification is necessary. According to a California study, such early treatment including institutionalization and in-home services and family counselling is costly in the early stages; however, long-range results show minimal cost and maximal benefits to the patient, family, and third-party payors. In our neighboring State of Massachusetts, Fall River has received federal funding to establish a program to serve the elderly problem drinker in the home.

In the State of Rhode Island, the legislature has mandated that all health insurers provide for alcohol treatment. Should we fail to provide such services to the rest of the population? This is a critical need among our seniors.

There is an ever-growing need in our society for day care for the elderly to enable the wage earners to leave during the day with the knowledge that their loved ones are safe and cared for. Providing for day care could be a cost effective alternative to nursing home care just as home health care is cheaper than institutionalization.

For those areas where no such service exists, there are already in existence agencies with the expertise, administrative structure, and professional skills to organize and operate day care centers. I am referring to local visiting nurse agencies whose record for quality service at reasonable cost is unimpeachable. To make this service a reality; however, some start-up funds must be available to provide security for the agency entering such a venture.

I would add also the recommendation that communities could utilize other components already functioning; for example, the food service program, the craft/recreational programs, and the transportation vehicles already being used by and for senior citizens.

Much is to be gained in cost-saving--program utilization and community enrichment by human service agencies working together to add a service to the existing network. Non-profit agencies and elderly citizens cannot bear these costs alone, we must rethink our spending patterns.

Historically, seed monies have been available to provide start-up costs for services to the elderly. This provision is essential to meet developing needs.

Thank you.

JAN 23 1984

Senator Pell

Hearing

January 16, 1984

North Providence Senior Center, Inc.

Young at Heart Senior Center, Inc.

Helen I. Nichols

In the duration of the last few years, Title III B Senior Center funds have been cut back tremendously. Programs and services which are desperately needed to help a Senior Center be more effective are no longer there. Federal regulations state that no Title III B monies can be used for recreational programs, maintenance of effort, or equipment.

It provides only for Administrative salaries. What can Administrators do with no place or programs to work with?

Every community is being stretched to its limit with all agencies looking to them for help. Even private fund raising efforts are stretched to their limit.

Our country is looking to help feed our elderly that are in need of nutritional programs. It should also look into feeding their mind and bodies by providing them with programs that can be implemented with the help of Title III B.

With Rhode Island being one of the top three states in the nation of having the largest population of senior citizens, it would be beneficial to all our elderly if you would support no more federal cuts on the Older American Act and possibly work to change federal guidelines on Title III B.

Senator PELL. I would be glad afterwards to answer any questions if people have burning questions, but the formal hearing is concluded at this point.

[Senator Pell had a brief informal discussion.]

Senator PELL. The hearing is both formally and informally drawn to a close.

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

Long-Term Care Under the Older Americans Act

TUESDAY, JANUARY 31, 1984

U.S. Senate,
Subcommittee on Aging,
Committee on Labor and Human Resources,
Washington, DC.

The subcommittee met at 9:35 a.m., in room SD-430, Dirksen Senate Office Building, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

Present: Senators Grassley, Hawkins, Denton, and Pell.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator **Grassley**. I am Senator Chuck Grassley, chairman of the Subcommittee on Aging.

I would like to open, and apologize for opening 5 minutes late, this hearing on the Older Americans Act dealing specifically with the subject of long-term care, and to say to you that we may be interrupted with votes this morning as the Senate considers the Criminal Code reform, and, if that is necessary, then we will try to—we will break at a convenient point in the rollcall and try to keep the meeting going as quickly as we can because we do have a long list of witnesses and a very outstanding panel of witnesses, and I hope we will be able to hear all of them between now and noon.

There is now, of course, what many consider to be a community long-term care mandate in title III of the act. Section 301(a) states, and here I am going to quote selectively, that "it is the purpose of this title to encourage and assist State and local agencies to concentrate resources in order * * * to foster the development of comprehensive and coordinated service systems * * * in order to * * * provide a continuum of care for the vulnerable elderly."

The purpose of the hearing today is to help the committee decide whether the resources of the Older Americans Act should be applied in greater degree than they are now to the problems of chronically impaired older people or whether the act is satisfactory more or less as it stands.

The National Association of Area Agencies on Aging has done us all a service by developing a position paper on this question. In their paper they propose to upgrade and further extend the responsibilities of the area agencies on aging in local community care systems. Their proposal has helped to bring into focus at least three overall issues on which we will gather testimony today.

First is the matter of balance between the long-term care programs of the Older Americans Act and the other programs sponsored under the act. Traditionally, participation in Older Americans Act programs has been open to everyone over 60. The question is whether greater emphasis on the long-term care population and programs will alter the traditional balance among all the programs. This question is particularly relevant because resources may be tight for the foreseeable future.

Second is the question of whether the triple A's have the capacity to fulfill greatly enhanced long-term care responsibilities. Clearly, many area agencies do have this capacity because they are doing it now. On the other hand, many triple A's do not have this capacity.

A third concern is with how quality can be assured in any expansion of community care services under the Older Americans Act.

Now, in an earlier version, the N4A proposal advocated or seemed to advocate, greatly increased authority for the area agencies in relationship to other organizations at the local level. I understand that they have modified this aspect of their proposal. But let me just say that it is clear that insofar as we get into considerations of enhancing the authority of one or another actor at the State or local level for the purpose of rationalizing or streamlining the administration of these services, we get into some very complicated intergovernmental issues.

Many respected people in this field think we just do not know enough at this point to stipulate from the Federal level how to finance and organize all long-term care services. And they advocate letting the many different developments underway in the States, through, for example, the section 2176 waiver program, proceed for a time so that we can learn more about what works and what does not work.

It is also the case that this subcommittee has a relatively limited jurisdiction in this long-term care area, and that many of the questions which would be raised by any such streamlining would go far beyond our jurisdiction.

Obviously, there are many other questions which can be raised about how long-term care services should be organized under the Older Americans Act and we will address some of these other questions today also. But these seem to me to be among the key questions facing those of us who must reauthorize the Older Americans Act this year.

We have also invited to testify a panel of mental health providers, who will be able to tell us about how chronic mental health problems of the elderly are being dealt with. And I believe they will have some suggestions for how such services might be improved under the act.

And, finally, we will hear from a panel of individuals whose organizations are involved in a variety of community services. We have included in this panel representatives of the long-term care gerontology centers in which I and other members of this subcommittee are very interested.

This is all I have to say by way of introduction, but I see my esteemed colleague from Alabama, Senator Denton, is here, and he was the Senator who had the responsibility for the last reauthorization of this act. And I have leaned on him considerably for advice as we proceeded for this reauthorization this year, and I would like to call on Senator Denton, if he has any opening statement.

Senator **Denton**. I do, Mr. Chairman, and you are very kind to invite me to make one.

I want to commend you, Mr. Chairman, in planning a fast and furious, as you put it, reauthorization schedule.

The act is of such vital importance to the Nation's elderly that we cannot afford to let it become bogged down in the hectic schedule of committee business.

I will be pleased to do whatever I can to help you achieve your goal of reauthorizing the Older Americans Act by the month of May.

Your dedication to the aging issue was proved by your interest in obtaining jurisdiction over this particular area. The old committee, which I chaired, had 2½ subcommittees in it, and the chairman of the overall committee, Senator Hatch, I think was proved correct to give you the chairmanship of a separate aging subcommittee, with jurisdiction over the Older Americans Act. I am sure that it will be looked at with more detail than would have been possible.

It is appropriate that this subcommittee devote one full morning to the issue of long-term care provided under the Older Americans Act. As the author of the Older Americans Act Amendments of 1981, I believe that an appropriate balance of services was included in title III, Mr. Chairman. However, I am aware that many groups of concerned citizens have submitted proposals recommending a greatly expanded program for long-term care, and I am sure that we did not have perfection in what we had before, so I will be happy to examine the proposals. But I hope that the subcommittee's hearings will produce a clear and accurate picture of the effect that an expanded program of long-term care services would have on our current nutrition programs and on the elderly population now served under title III.

I extend a warm welcome to the witnesses; I look forward to the testimony. I will have a representative here to hear it, and if it meets with your approval, Mr. Chairman, I may submit questions for those witnesses to respond to in writing.

Again I thank you for permitting me to make this statement and congratulate you on the compassionate and efficient way you have been handling the issues under the jurisdiction of Aging Subcommittee.

Senator **Grassley**. We have asked each witness to keep remarks somewhere between 5 and 7 minutes. I emphasize that at the outstart because sometimes I wait until we get into the middle and then I get an unfair situation where some people have gone longer than others. For us to get done by noon, it will be pretty necessary for us to keep on that schedule. So for those of you who are early on the panel and if you have forgotten that, I will be understanding of that, but for those others who are coming along, that would give you an opportunity to think in terms of summarizing. And also I would remind everybody from an administrative point of view that entire testimony will be printed in the record unless you desire otherwise, and also the record will be left open for 15 days for any additions or anybody who was not—who was not invited to testify, who desires to submit a written statement for print. That will be accepted in that 15-day period of time. And also it gives Senators who cannot be here, or even in my case where I might be here but not have time to ask all the questions that need to be asked, for us to submit questions in writing, so I would appreciate it very much if everybody would be open to answering questions in writing, particularly from other members of the subcommittee and to get those responses back as well in that same period of time.

For our first panel, we have two individuals who were able to bring broad perspectives to the issues we will consider today. Dr. Rosalie Kane comes to us from the Rand Corp. and the University of California at Los Angeles. She has written widely on the subject of long-term care on questions as varied as how we should assess the functional status of individuals all the way to how we organize long-term care systems.

Dr. Sharon Patten comes from Minnesota where she is affiliated with the Humphrey Institute for Public Affairs. She recently coauthored the book called "Long-Term Care for Older Persons: A Policy Perspective." And we are fortunate to have both of them here today. And I would welcome them both to come, and I would ask Dr. Kane to be the first to start.

Welcome to both of you.

We will listen to both of you before we have dialog.

STATEMENTS OF DR. ROSALIE KANE, THE RAND CORP., UCLA, DIVISION OF GERIATRICS, SCHOOL OF SOCIAL WORK; AND DR. SHARON PATTEN, ADJUNCT FACULTY MEMBER, HUMPHREY INSTITUTE OF PUBLIC AFFAIRS, UNIVERSITY OF MINNESOTA, LONG-TERM CARE AND HUMAN SERVICES CONSULTANT

Dr. **Kane**. Senator Grassley, thank you for holding this hearing and thank you for inviting me to testify.

I will make my remarks quick and divide them into two parts, first some general comments about community long-term care and case management as I was asked, and then some comments on the potential roles of Area Agencies on Aging and facilitating community long-term care. I request that my full written testimony be inserted in the record. The opinions in both my oral and written testimony are my own and that they do not necessarily reflect the views of the Rand Corp. or its research sponsors.

First of all, community long-term care is not available in any reliable consistent fashion in the United States, and this is true even for people who can afford to purchase it. And yet an overwhelmingly important point is that the development of a community long-term care system is a highly desirable goal. Undisputably older persons prefer the dignity, autonomy, and familiarity of their own communities, and similarly families dread having their relatives enter nursing homes for permanent stays. By now, there is considerable evidence that qualifies initial optimism that simply providing community care produces an immediate effect on the overall use and costs of nursing homes. But community care still has a desirable long-range effect because once an array of community services is in place and once they have earned the confidence of the public and professionals, then the climate is created that enables States and communities to constrain the supply of nursing home beds. Ultimately, of course, that supply of nursing home beds is what dictates use and costs.

The kind of community long-term care services that are most needed are relatively unspecialized and untechnical. Those are the kinds of services that are already provided by family members. So, therefore, an effective community long-term care program needs to be responsive and flexible in the way it fills in gaps and augments family care wherever necessary. Services need not always be intensive or extensive, but their timing and form has to fit human needs. This means after hours, weekends and personnel that are willing to perform a great variety of functions.

Publicly financed long-term care as we have it now in the United States, is largely a health program. As such, it has incorporated some of the disadvantages of health programs, which tend to become professionalized, technological, routinized, impersonal, regulated and, above all, expensive. Because of the incentives created by medicare and medicaid, publicly financed long-term care is also largely institutionally based. In the narrow health context, sending people to nursing homes even seems efficient because the unit cost of the nursing home today is much less than the unit cost of a hospital day. Because of this, the efforts to develop community care have largely been cast as alternatives to nursing home care, so we have evolved to a topsy-turvy situation where instances of community long-term care have to prove themselves by whether they are targeted to those who normally would be in nursing homes.

More ideally, each instance of nursing home care should be judged as appropriate only if the care cannot be provided in the community once that array of community based services is present. Again speaking ideally, community long-term care including residential services would probably be best taken out of the health system entirely. Then those persons receiving the family-like services that constitute long-term care could receive their health care from doctors and hospitals and public health nurses and so on just like everybody else does. Then only who genuinely need continuous medical supervision and high technology interventions, either for rehabilitation or for life sustenance, would remain candidates for residing in health facilities for extended or permanent stays. This would be a small fraction of the population that is currently in nursing homes.

Some form of case management is a prerequisite to developing a community long-term care service that is cost effective in meeting human needs. Case management is defined as a system for locating, coordinating and monitoring a group of services. Traditionally case management has come to include processes of case findings, of comprehensive assessment, of care planning, of implementing plans, and of monitoring plans. The important point is that case management has a dual responsibility: (1) Toward the older people to organize services on their behalf, and (2) toward the public to ensure that the community and residential resources are used carefully on behalf of the people who really need them for functional reasons and in programs of acceptable quality.

For case management to be that kind of organizing force in community long-term care, it should meet several criteria. In the interest of time, I am just going to enumerate the criteria. Further amplification is in the written testimony. Case management systems need, first of all, access to and control over a set of resources in the community. And ideally that would include some residential resources.

Second, they would need public visibility and accountability for the costs of the services that they provide and the effectiveness of those services.

Third, disinterestedness is required, and that disinterestedness probably would come best if case management is separated from service provision. Case management should not be done by organizations that have incentives to order the very kinds of services that they themselves provide.

I think, too, that the program scope should encompass a defined geopolitical area so that the case management system can monitor patterns in the supply of, demand for and quality of services in the community, and be accountable to that community.

And, finally, case management systems should be well coordinated with health care providers so that any remediable cause of functional dependency can be identified and treated. It would be inefficent as well as inhumane to provide long-term care to compensate for functional dependency if that functional dependency could be eliminated in the first place.

At the Rand Corp., we have been studying long-term care programs in several Canadian provinces where community long-term care services are coordinated by case managers, who also control entry into any form of residential care. Based on our observations, particularly in British Columbia and Manitoba, I would make the following points.

It is feasible to develop an accountable disinterested case management program and to do that fairly quickly once the mandate has been given. Case managers in such programs can prove to be frugal purchasers of services. And the public demand for such service seems to settle at a low and manageable level. That has been verified also by Massachusetts programs.

Third, it is important that the decision about how much care and what care is needed be made first and independently of a decision about whether a residential facility is needed. Presently in the United States, we approach those decisions the other way around.

And another point learned from the Canadian experience is that homemaking is by far the most necessary needed service, the service that is used the most, and that becomes the backbone of the community elderly home system. Perhaps homemaking is paramount because of its versatility. Other services—e.g., meals, delivered meals, day care and respite care also have their place in a long-term care system.

A case management system proved to be compatible with substantial consumer choice, a case management system proved to be compatible with a complicated environment of service provision including both for-profit and nonprofit providers in the community. It was also possible to develop a case management system where the role of medical personnel in determining where people are to live was appropriately secondary. Medical input is crucial to help in decisionmaking, but the case manager and the client make the ultimate determination of where the person is going to live.

Finally, from the Canadian experience, we found that even in rural areas, the supply of homemaking and other essential services rapidly grew to meet the need.

Now, as you already said developing a non health approach to long-term care and instituting case management with true authority over a wide range of resources requires reexamination of legislation well beyond the Older Americans Act, Ultimately, funds that presently are housed in a variety of programs would best be consolidated into a single fund to purchase long-term care. Some States are already doing that. However, the Older Americans Act is an important component, and this reauthorization provides an opportunity to consider what directions would constitute positive steps toward the kind of long-term care that Americans want.

The N4A proposal that AAA's should be mandated to focus their title III activities decisively on long-term care and to exercise responsibility for case management in their communities. For some AAA's, as you said, the step has already been taken, but for most it would require substantial redirection.

I would favor encouraging AAA's to target their attention on the frail elderly to a greater extent than is already done because this is the group that most requires the advocacy and the coordinating services that AAA's are mandated to provide for older persons of all incomes.

What about AAA's ability to do case management? Currently AAA's as a whole do not have the skills for case management and long-term care, and they certainly did lack the community agreements and the control over resources that is needed in most effective types of case management systems. But I would say that no other organization in the community has the capacity either. Case management systems will need to be developed and the mandate for their development must logically precede the actual capability. So I find myself asking if not the AAA's, who, and if not now, when?

Given the desirability of developing case management, AAA's would be logical candidates for several reasons. They are social rather than health programs; they lack the stigma of welfare; they already have some experience with long-term care delivery through the established title III programs; they have relationships with community agencies and volunteers. Some are doing it already and, by definition, they are advocates for the elderly and coordinators of service.

On the other hand, if AAA's were to serve in this role, considerable behavior change would be needed, and there would be some pitfalls to avoid. Some existing service contracts under title III would need to be redeployed to emphasize the needs of the frail elderly more; new relationships would be required with health providers; much work would be needed to secure community agreements, giving AAA's responsibility for allocating services. AAA's would need to show that they were equally concerned with cost containment as with advocacy, at least as far as this case management community long-term care program, and there would need to be work toward the consolidation of funds at the State level.

Finally, some AAA's would need to change their style for case management activities. Case management cannot really be subcontracted out, in my opinion, to an array of other community agencies, most of whom are service providers. This would defeat the goal of creating a system with an easily identifiable publicly accountable disinterested party that makes decisions about the allocation of resources within an overview of human need from a community and an overview of the totality of available services.

So with those caveats, I welcome the willingness of AAA's as reflected by the N4A to take leadership in long-term care and to develop a case management capacity. I would welcome language in title III that establishes the centrality of long-term care in the title III mission, that encourages and provides resources to AAA's to facilitate the development of a case management capability in their communities, and is permissive in allowing State units on aging to use Older Americans Act resources as part of any planned consolidation of funds for community long-term care that is being worked out in various States.

Thank you.

[The prepared statement of Dr. Kane and responses to questions submitted by Senator Grassley follow:]

PREPARED TESTIMONY OF ROSALIE A. KANE

Senator Grassley and members of the Senate Sub-Committee on Aging, I am Rosalie Kane, a researcher at The Rand Corporation in Santa Monica, California. For the last ten years, I have been studying, planning, and evaluating aspects of long-term care for older persons in the United States and other countries. I am honored to be invited here and commend the subcommittee for holding a hearing dedicated to a broad consideration of how to develop effective and efficient community long-term care programs in the United States and the potential roles for Area Agencies on Aging (AAAs) in this important endeavor.

My testimony emphasizes the importance of developing a capability for community long-term care in this country. Both humanitarian and practical reasons dictate that goal. Furthermore, some responsible and responsive system of case management will be a key in developing a coherent approach to long-term care. The Older American's Act is not the only statute that needs to be examined in the light of a consistent long-term care strategy, but it is an important component. First I will comment on community long-term care and case management in general, followed by specific consideration of how Title III of the Older Americans Act might contribute toward a positive and efficient system of community long-term care.

Community long-term care programs are unavailable in the United States today in any reliable, systematic fashion. Even individuals who can afford to purchase long-term care services usually have difficulty locating and arranging them at time of need. This situation is all the more worrisome because community long-term care for the frail elderly is a highly desirable goal. Study after study has shown that older persons prefer the dignity, autonomy, and familiarity of their own communities whenever possible. Moreover, a well-established array of community services for the frail elderly creates the necessary conditions of public and professional confidence that allow purposeful control of the supply of nursing-home beds. Developing community services and even offering expanded benefits for some such community services seem to have no immediate direct effect on the use (and therefore the cost) of nursing homes. Someone else in the large pool of potential users will take the nursing-home bed. But the very existence of community programs creates the political conditions that permit constraining the supply of nursing-home beds within planned tight bed-to-population ratios and improving the quality of institutional care by refusing to purchase it from facilities judged substandard.

A current Rand study that Robert Kane and I are doing in several Canadian provinces with funding from the Henry J. Kaiser Family Foundation bears out these contentions. Once a community care system is in place, it is much easier to exert leverage over institutional supply and institutional use. Given projected increases in the population over age 75 at high risk of nursing-home care, a community capacity is urgently needed to prevent a commensurate growth in institutional supply.

Presently there is a dearth of the kind of long-term care programs that provide the service most needed to foster independent community living at a manageable cost. This dilemma is best understood by briefly considering what long-term care is, who among the elderly need it, and how it has evolved in the United States. (Useful background discussion of these issues was generated at an AoA-sponsored conference in Williamsburg, VA, in June 1980, reported in *Policy Options in Long-Term Care*, edited by Meltzer, Farrow, and Richman, 1981.)

Long-term care consists of those personal care and supportive services needed to compensate for functional limitations. Although persons with expertise in aging should plan, supervise, and train personnel for long-term care programs for the elderly, the long-term care services themselves are largely unspecialized and untechnical. The functional impairments of older people can be divided into those affecting the ability to do basic personal care (such as walking, bathing, dressing, using the toilet, getting in and out of bed or a chair, and eating) and those affecting the ability to manage a household (such as cooking, cleaning, shopping, and managing money). The kind of help needed to compensate for such functional impairment can be and for the most part is given by family members. Wives and husbands and adult children of the older person are most frequently the long-term care providers, but other relatives (such as grandchildren, brothers and sisters, and nieces and nephews) are also involved. The services include laundry, cleaning, shopping, cooking, chauffeuring, and assisting with details of personal care. Sometimes the environment can be simplified through special equipment, reorganization, or even relocation. Whatever need for human help remains is met through long-term care.

The likelihood of needing long-term care increases dramatically as people pass their 75th birthday. Age 65 represents "statistical aging," but persons of that age are unlikely to have functional impairment unless they carry it over from a chronic illness suffered during their adult years. The 1979 National Health Interview Study showed that for every 1000 persons between 75 and 84 living in the community, 114 needed help with one or more basic physical activities, and 348 per 1000 over age 85 needed such help. Similarly, 142 persons per 1000 between ages 75 and 84 and 399 per 1000 over 85 needed help with one or more household activities. Some help consisted of special equipment, but the numbers needing help from another person for one or more tasks are instructive. Only 70 of 1000 persons 65 to 74 needed personal help; 160 of 1000 persons 75 to 84 needed personal help; and fully 436 out of every 1000 community dwelling persons over 85 (approaching 50 percent) needed some personal help. Add to this the people living in board-and-care and other protected settings, and the numbers of people outside nursing homes who need some kind of human assistance is formidably high.

But what kind of assistance is needed? Long-term care services might almost be called "familial services" because they augment or replace what a family cannot or will not do. By now it is well understood that family members in the United States have not deserted their frail elderly relatives. Rather they make Herculean and protracted efforts to provide long-term care. Geographic mobility, obligations in the workplace for both women and men, and competing multiple demands on the time and finances of family members may make it impossible for some families to do the whole job and impossible for other families to finish the job they began. Note, too, that many older people have no families, and still many others live in family constellations where the potential caregivers are also elderly and limited in their own abilities to do certain heavy tasks. Long-term care services that fill such gaps need not always be extensive, intensive, or expensive, but they do need to be flexible. They may be required most especially at odd hours of the early morning, the evening, or weekends. They may be needed intensively for a few weeks at a time when a family member is unavailable. They may require a few moments of attention and checking at intervals rather than a sustained period of attendance. They are best delivered by personnel who are willing to turn their hands to a wide range of activities--long-term care is not the place for a union-like division of labor.

One reason for the failure to develop mechanisms for the kind of long-term care described above is that, in the United States, long-term care has evolved as a health service. Characteristically it has been institutionally based, stimulated by coverage of limited Skilled Nursing Facility (SNF) care under Medicare and coverage of both SNF and Intermediate Care Facility (ICF) care under Medicaid. Long-term care as a health service is prone to develop the characteristics of the health system in the United States today--that is, it can become technological, highly professional, routinized, regulated, and expensive. At the same time, because long-term care is relatively inexpensive compared to hospital costs (at least per unit cost), there is an incentive (in the name of an efficient health system) to "place" hospitalized older people in the first available nursing-home bed at a time when they are most vulnerable and their relatives most anxious.

Under the current system, community long-term care programs have been cast as alternatives to the nursing home and have needed to demonstrate their utility by that standard. To demonstrate an effect on nursing-home use and public costs, however, it is then necessary to target the services strictly to persons in imminent danger of a nursing-home admission. Such tight targeting is understandable in light of the burgeoning expenses for nursing homes under Medicaid, but it interferes with the orderly development of resources for services to meet the needs of the frail elderly in the community. And it is only when these resources are in place that the nursing-home can take its rightful place in a system. Nursing-home care should be an alternative when community care is inappropriate rather than the reverse. Tight financial targeting of community long-term care services to a population eligible for Medicaid is also dysfunctional. Many older people who need some amount of long-term care do not reach Medicaid eligibility until after they have entered a nursing home and spent down to that level. It is then far too late to offer a package of coordinated community services.

The development of long-term care as a health service is counterproductive when one recognizes long-term care as family-like, nontechnical, nonspecialized services. The less specialized the labor and the more flexible the program, the more effective and efficient (and perhaps humane) the long-term care will be.

Both community and residential (a word I prefer to institutional) long-term care might better be viewed not as health programs but as supportive human services to meet the needs created by functional impairment. This assumes that persons receiving long-term care will receive their health care from physicians, hospitals, public health nurses, and other such personnel in exactly the same manner as persons in the population who do not receive long-term care. If we were to introduce such a system, there would still remain a sizable group (but much smaller than the group now in nursing homes) whose genuine need for continuous medical supervision and high technology interventions would require extended or permanent residence in a health facility. Such facilities could be viewed as long-stay hospitals (with some beds for long-term rehabilitation and some for specialized custodial care) and placed under the direct jurisdiction of health programs.

A strong argument can be made that long-term care programs should be mediated by a case management system. Unfortunately, case management has entered common parlance and has been hailed as a panacea without clarity or agreement over its meaning. As defined in the 1981 Omnibus Reconciliation Act, case management is "a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a defined person or group." This definition is helpful because it emphasizes the system side of case management as well as its responsibility to individuals. Case management is usually construed to involve several processes: case finding or screening; comprehensive functional assessment; care planning and implementation; and monitoring of service. Reassessments occur at regular intervals and/or are triggered by special requests or circumstances. A management information system is necessary to track individual clients and to monitor the extent to which community resources are congruent with need.

Case management along these lines is becoming a standard feature of long-term care reform. In the 1970s, several important demonstrations under 1115 Medicaid waivers were conducted to examine the effects of case management combined with a wider array of community benefits. The recently launched National Channeling Demonstration is the most rigorous of such demonstrations and will afford the best information yet about the effects of case management of various types on long-term care outcomes and costs. Since 1981, states have been able to apply for 2176 waivers to develop expanded long-term care services in the community on an operational basis; case management has been the backbone of most projects. Some states have launched their own long-term care demonstrations, and others are in the process of developing state-wide long-term care programs mediated by case management.

From all this activity, it has become clear that case management programs in the United States differ on several dimensions. Some can authorize or deny services and dictate the intensity of reimbursable service, whereas others simply arrange care with no power to purchase care or deny reimbursement. Some case management programs involve intensive relationships with the older person, but others are rather perfunctory, relying on reports from providers about the nature of service needs. Some case management programs are tightly targeted to those at imminent risk of nursing-home care, and others are loosely targeted. Some manage a wide array of health and social services, whereas others manage social services only. Some cease to manage the case after the individual has entered a nursing home, and others follow the client for at least a specified time to facilitate re-entry to the community. Case management functions are sometimes divided, with one group or organization responsible for the assessments and another for continuing case management. In some models, case management is provided by the same organization that provides some or all of the services being managed.

Case management can be the all-important ingredient in a responsive and responsible community long-term care program. Such a program must meet the needs of older people with functional dependency while accepting the responsibility for wise use of limited funds and for encouraging the evolution of high-quality services in a given community.

Our studies here and in other countries suggest that a case management program should meet certain conditions to be most effective:

- To manage care, the case manager needs access to and control over a set of resources. Ideally these should include community and residential resources.
- Case management systems should be publicly accountable for the costs and effects of the program. The case management system will learn over time the smallest increments of service that are still sufficient to maintain community functioning and will authorize at that level.
- The case management system should be reasonably disinterested. This argues for a case management function that is divorced from service provision. The case manager's organization should not profit financially from the services ordered.
- Case management systems should operate within logical, identifiable geopolitical units so that patterns in the supply of and demand for services and the quality of services can be monitored. This suggests that a city or a county is the appropriate unit for case management.
- Case management should function within a philosophy that seeks to augment and support family care when necessary but avoid supplanting it.
- Case managers must be skilled in processes of functional assessment and care planning.
- Reassessments must occur at regular intervals. Such reassessments can lead to the reduction or elimination of service as well as the augmentation. If reassessments are triggered only by provider requests, it is unlikely that requests for service reduction will occur.
- Good coordination is needed between the case management system and the system of health care. Sometimes functional dependency can be reduced through medical intervention, and in such cases, it is inappropriate and inhumane as well as inefficient to provide supportive care for a functional disability rather than correcting the underlying problem. Similarly, case managers need a close relationship with hospital personnel so that a client will not be lost to the case management system when the help is most needed.

For the record, I will briefly describe the long-term care case management program that exists in British Columbia, a province of about 3 million people. Each provincial resident is entitled to nursing-home care benefits regardless of income or assets if his functional condition warrants it. The consumer pays a fixed amount, well affordable under the minimum income security program in the province, to compensate for hotel costs. British Columbians are also eligible for homemaking on a sliding fee basis. Anybody wishing to be considered for long-term care in British Columbia contacts a local long-term care office and receives an assessment by a case manager. The case manager decides on the basis of the assessment what intensity of care is needed. Then, based on the older person's social situation and preferences as well as functional limitations, an independent decision is made about whether the care will be given in the community or in a residential facility.

If community care is the plan, the case manager authorizes the number of hours for homemaking and various additional services. If residential care is the plan, the case manager authorizes the level of care and assists the individual in getting to the facility of choice. Often the person receives care in the community while waiting for a vacancy in the preferred residential facility. A wide variety of for-profit and nonprofit care providers compete in the environment, but all service under the benefit program is authorized by the case managers, who effectively coordinate long-term care in a given community. Since their beginning in British Columbia in 1978, the long-term care programs have enjoyed good public credibility.

Once caseloads became established in the first year or so, the demand for new service stabilized and remained consistently low. Moreover, the amount of homemaking authorized by case managers was, on the average, impressively frugal (sometimes amounting to only a few hours per week). Per capita long-term care costs in British Columbia (i.e., residential and community combined) are lower than in the United States. Theoretically, a person judged not to require long-term care could purchase it anyway, but this almost never happens. There is no need for older persons to risk financial destitution by entering a facility with their own funds when they know that, once they reach a definable level of functional impairment, care will be provided as part of the program.

The province of Manitoba has developed a similar case management program for allocation of homemaking and other community long-term care services and for mediating admission to nursing homes (called personal care homes in Manitoba). Unlike British Columbia, Manitoba's case managers close the case once the older person enters a personal care home. However, in Manitoba, nobody can be admitted to a personal care home before a multidisciplinary panel formally examines the appropriateness of the admission. This includes a review of medical data and a consideration of the possibility that further diagnostic or therapeutic work is needed.

These two Canadian provinces pinpoint lessons for the United States.

- Their case management systems can make allocations of service equitably and hold costs steady while satisfying the public.

- In both provinces, homemaking is the single most important service, although home-delivered meals, day care, and respite admissions to residential facilities have an important place in the system.

- Case managers have the power and public accountability that come with control of services and responsibility in a logical geopolitical area. The case managers maintain continuity of involvement rather than turning management over to the care providers. They are able to tread the difficult line between being advocates for the older person and responsible husbanders of the community's resources.

- Consistent with the organization of these programs as human services rather than health programs, the physician's role is contributory rather than central. Medical information is essential data for decisionmaking, but the decision about service needs is made by case managers, not physicians.

- In contrast to predictions heard in the United States, the supply of homemaking services adjusts rapidly to meet the new purchasing power of the case managers. Even in rural areas, the lag for startup was hardly consequential. This observation contradicts the common argument that one must resort to institutional care because the supply of home care is so scant; the real issue is the commitment to pay for home care.

I have argued thus far that a range of community long-term care services is needed; that access to these services should be mediated by an accountable, disinterested case management system; that ideal long-term care should be viewed as a series of family-like services that support or substitute for the tasks family members perform in compensating for functional dependency rather than a set of technical, specialized health services; and that case managers should make decisions about the amount of care needed independently of decisions about whether a residential facility is needed.

To mount such programs of case management and to provide the expanded resources inherent in a community-based system, some front-end money is needed. There will be dividends later on in the increased ability to limit the supply of residential care. In the long run, a community care system should facilitate controlling public costs of nursing homes. Furthermore, a reliable, flexible, responsive system of community services that is trusted by professionals and users alike also has a good likelihood of reducing hospital use by the elderly as well. (For example, outpatient surgery may be done with temporary intensive homemaker support or, more likely, hospital stays can be planned and kept short.) But there is no escaping the need for some pump-priming to get the system in motion.

Although money is needed to build community services, a community long-term care system and its case management component need not be financed exclusively or even primarily by taxes. In the Canadian provinces, the long-term care programs described do happen to be financed publicly, although the delivery system is diverse and competitive. However, money for long-term care can be raised privately through a variety of mechanisms, including insurance schemes. The key is to pool revenues from various public and private sources and thus allow the case manager control over the supply of services. Also, some consumer co-payment for services is desirable. (This is another reason to keep the services from becoming so highly professionalized that they are unaffordable to middle-class retirees.)

The National Association of Area Agencies on Aging has proposed that the Older American's Act be amended to refocus Title III activities more decisively on long-term care and to vest responsibility for case management in long-term care to AAAs or their designated contractors. If enabling legislation were to be enacted in this direction, it would represent a commitment to community-based long-term care and a rather dramatic change in direction for some AAAs. It would also represent a logical evolution in the direction AAAs are already moving. The services authorized under Title III have been historically directed to the entire population over 60, and many programs sponsored by AAAs, almost by definition, have had limited impact on the functionally impaired elderly, many of whom are homebound. However, over the last five years or so, considerable attention has been given to targeting services more specifically to the frail. This is a logical direction for AAAs, and one that is feasible for organizations that have gained some maturity and have undertaken the constituency-building that was required in their earliest years as a coordinating and advocacy force on behalf of older people.

An acknowledged focus on long-term care is a responsible and laudable step for AAAs. It recognizes that the functionally impaired elderly, regardless of income, remain in the group most in need of advocacy, service coordination, and help from an agency that, by statute, is dedicated to the well-being of older people. It gives visibility to the needs of the frail elderly and to AAAs in their advocacy and coordination roles. The question now is how the willingness of AAAs to invest themselves in long-term care can be incorporated into a program that meets the criteria for an effective community long-term care system and at what cost. Will the AAAs be prepared and permitted to divert resources from programs aimed at the well elderly to those for the frail elderly? Will they be given sufficient resources for the needed front-end investment?

The 660 AAAs in the country are diverse in their interests and capabilities. They vary in the extent that their traditional services--i.e., information and referral, transportation, multipurpose senior centers, etc.--are used by the frail elderly and are adapted to their needs. Recent efforts to develop a long-term care capacity, however, are encouraging, although uneven. Home delivered meals, transportation, and homemaking are definitely planks of a long-term care program. It is especially encouraging that some Older Americans Act programs (such as escort and transportation, supportive assistance, and congregate meals) have been extended to seniors who live in board-and-care homes. (This development is important because a board-and-care home is a nonmedical congregate residence, and could be considered as a residential component of a system of community and residential long-term care that was developed outside the health system.) The ombudsman program for nursing homes (which was more recently extended to board-and-care homes) also provides an important link to long-term care. Some states--for example, Massachusetts, Pennsylvania, and Florida--have developed community long-term care systems with AAAs at the hub, and other states are now in the planning stage.

Who should be responsible for case management? At present, no agency has consistently evidenced the requisite capacities. As with many such enterprises, the capacity will not develop until the mandate has been given. The experience of Canada and of states like Massachusetts and Pennsylvania argues that policy direction must precede full capability. Although the statistics generated by AAAs to suggest an already heavy involvement in case management are clearly exaggerated because many are counting management activities that do not meet the description offered earlier in this testimony, we might do well to capitalize on the AAAs motivation and create the sanction and circumstances that allow them to build a capability for case management and leadership in community long-term care.

AAAs do have some decided advantages as a focus for case management. They have a clear advocacy role on behalf of the elderly and some precedent for organizing supportive services for the frail elderly. They clearly fit into the social service rather than the health side of the service-delivery system. They usually have relationships with a wide range of community agencies and access to a pool of senior volunteers. There is no welfare stigma associated with the services they provide. Undoubtedly only a minority of AAAs have the current capacity to do case management, just as only a minority of communities have forged the interorganizational agreements to permit an effective case management system. Still fewer AAAs have control over a sufficient range of resources to make their case management in long-term care viable. But a case management capacity will never develop unless a conscious decision is first made to work toward creating it.

Certain pitfalls must be avoided, however. Although it is impossible to prescribe a single solution to long-term care problems in this heterogeneous country, one can enumerate with certainty some things that are not needed. More fragmentation is not needed. Brokers to broker other brokers are not needed. Redefining services for the well elderly as long-term care is also not needed.

AAAs exploring the arena of long-term care and case management will need to contend with these issues. They need to resist dividing case management functions or clients for case management across a series of contractors in the community. Such a step defeats the purpose of developing a central system for defining need and allocating resources. Some AAAs have fulfilled their mandate for delivering information and referral (I&R) by making multiple small contracts to many agencies, each of which promises to do some I&R. This did not work well with I&R and would be disastrous with case management. The accountability inherent in the system requires some readily identifiable responsible organization with an overview of the system.

With the diversity that characterizes local communities in the United States, it is unrealistic to assume that a single organization will prove best for the case management role in every county in the country. But AAAs could be likely candidates for the role in many circumstances and could easily become a catalyst for community planning in all jurisdictions. This reauthorization of the Older Americans Act provides an opportunity to give AAAs direction to take a major responsibility for long-term care and to develop a much-needed case management capability in their communities.

Ultimately the redirection of long-term care in the United States will require a creative bridging of the several programs that finance and provide service to the elderly. An effective case management system requires the consolidation of funds from at least the Social Services Block grant, Title III of the Older Americans Act, and the Medicaid program.

How do we achieve this transition? In the past, we have looked to individual states to pioneer in developing new approaches to long-term care. Indeed, states like Massachusetts, New York, and California have already moved into active development of different community-based case management mechanisms, and numerous others are using 2176 waivers to embark on similar efforts. A good way to begin the transition is to establish a climate for creativity among those states willing to venture forth. I hope that permissive language can be used in the Older Americans Act to allow states with an interest in creating a consolidated long-term care funds to work with their State Units on Aging for that purpose.

Ultimately it will be necessary to re-examine other legislation, especially the Social Security Act, to be sure that all legislative direction points to a clear and consistent long-term care policy. This hearing on the long-term care provisions of the Older Americans Act will, I hope, be a step leading to that larger task.

RESPONSE TO QUESTIONS ARISING FROM
TESTIMONY TO THE SENATE SUBCOMMITTEE ON AGING

January 31, 1984

Rosalie A. Kane, D.S.W.

February 20, 1984

Views expressed in this paper are the author's own and are not necessarily shared by Rand or its research sponsors.

1. *Dr. Kane, you seem to be willing for the Older Americans Act network to move fairly substantially into this area [long-term care activities], perhaps undertaking a major change in direction in the process. Have I understood your presentation correctly?*

Yes, I do believe the Older Americans Act network should engage substantially in long-term care activities. This is not an abandonment of traditional functions of advocacy, coordination and planning but an appropriate application of those functions on behalf of the frail elderly. The service network supported by contracts under Title III of the Older Americans Act best assists older people when scarce service dollars are targeted toward persons with functional impairments and/or multiple social problems. This means inevitably that more attention will be focused on those at the upper end of the age spectrum--over 75 and in their 80s. Such a shift is highly appropriate, given the demographic projections for an increased population among the very elderly. Also the reality is that most Americans in their 60s and early 70s have little need of a specialized service system. By shifting emphasis toward the needs of the frail elderly, area agencies will simultaneously meet the most important problems of *family* constellations of persons over 60 (because many persons over 60 are involved with at least one frail elderly relative). They will also address issues that create general concern and anxiety in the whole population over 60 who contemplate the prospect of functional impairment in their own futures.

2. *Dr. Patten, I take it from your treatment of case management that you do not think it would be a good idea if we required area agencies on aging, or state agencies on aging for that matter, to develop case management systems? Dr. Kane, how do you feel about that?*

It would be premature to *require* case management of area agencies or state units on aging, but it would be useful to *encourage* such activities by permissive language in the act. As my testimony indicated, some states and communities have already evolved case management systems. They have shown that state units and area agencies can be effective in these roles. I favor a stance that encourages area agencies to develop a case management capacity when such a capacity does not exist in the community and to work to strengthen a case management system when it does exist. At the very least, area agencies and state units can be catalysts for action.

3. *At least two national organizations have cautioned the committee, in position papers presented to us, that some services are lacking in many planning and service areas, and that this dictates a service development strategy rather than a case management strategy as the highest priority for the moment, at least in some jurisdictions. Can you comment on this for us, please.*

It is very true that case management is somewhat hollow in a region bereft of services. In those instances, the most case management can hope to accomplish is to provide information for seniors who have incomplete knowledge of existing resources, to allocate nursing-home care appropriately, and to document gaps in services. However, the documentation of such gaps is a critical contribution.

Once the organized demand for services exists, the supply will follow. Community-based long-term care services--particularly homemaking services--will develop amazingly quickly to meet the ability to pay for them. The response of the states to the 2176 waiver opportunities certainly suggests that reimbursement will be increasingly available for community long-term care. It is also true that the *professional perception* of availability of home services tends to lag behind actual availability. Physicians and hospital personnel sometimes suggest nursing-home care in ignorance of true availability of community service. Ironically, even in areas where community services are in short supply, there is the paradox that those scarce services may be underutilized and thus experience no market pressure to expand. Case management can stimulate that demand. My short answer is that work is necessary on *both* fronts--the stimulation of an appropriate array of community services and the development of a case management capacity. The two areas of endeavor complement each other.

4. *Your definition of case management states that, as a consequence of the need for accountability, city or county government is probably the appropriate unit to run case management activities. You know, of course, that some 264 area agencies are not governmental units. Would this disqualify them, in your opinion, for the case management responsibility?*

I welcome the opportunity to clarify this point. Public visibility and accountability are critical, but it does not follow that city or county governments are the only organizations that can do case management. The important issues, it seems to me, are (1) that the management be vested in a readily identifiable organization, (2) that the organization is held responsible for the decisions it makes and the funds it disburses, and (3) that the scope of the activity encompasses a logical service area such as a city or a county so that service patterns can be examined and enhanced. The accountability requirement also argues against fragmentation of case management among many separate organizations. Although governmental area agencies may gain more ready acceptability as case managers, area agencies under other auspices can be successful. Massachusetts' area agencies are responsible for case management systems with accountability and visibility, although most of these area agencies are nongovernmental. Also Maine's AAAs--operating as private, nonprofit organizations--are instrumental in long-term care and case management (as Patricia A. Riley's testimony of July 14, 1983, before this committee indicated).

5. *You both spoke very eloquently about the importance of families in providing help for dependent older people, and I think both of you are exactly right in emphasizing the importance of preserving the family as the major support for those older people. It's sometimes suggested by people who concern themselves with these matters that introduction of formal services can lead families to reduce the help that they give. Do you think this is a potential problems as more long-term care services develop, or would it be a problem if we were to provide tax credits and that kind of thing, which might encourage families to begin to purchase care for their older relatives?*

Experience in the United States and in Canada suggests that the provision of formal services does not lead families to cease providing direct services to the elderly. Moreover, [illegible] case management system has a particular role in this assurance by recommending service levels that compensate for care the family cannot provide rather than as a substitution. Indeed, interested family members should participate in developing the care plan.

If tax credits are used to subsidize the purchase of services, case management will still be important, but less potent, in advising families about available resources to meet needs most appropriately. Tax credit funding mechanisms should have no greater effect on family responsibility than would public funding.

There is always a concern that long-term care services will simply replace what the family would do anyway and therefore have a marked inflationary effect. It is important, therefore, to recall that a substantial number of elderly people have no family members available and that others are supported by family who are themselves elderly, somewhat functionally impaired, and on extremely limited incomes.

> 6. *I take it your position is not that we should designate the area agencies as the focal point for long-term care at the local level, but that we should enable them to develop to the point from which they might be logical contenders for that honor if and when the local communities or state governments begin to designate such focal points.*

Yes, that is a correct interpretation. Perhaps, however, I would put it a little stronger. We should *encourage* rather than just enable AAAs. In the full written testimony I indicated some advantages of the area agencies in the role of case manager, emphasizing the lack of welfare stigma, among other things. However, case management in long-term care crosses jurisdictions and cannot be unilaterally declared or designated. The planning and coordination activities of state units or area agencies exploring case management roles require interagency and interdepartmental collaboration.

> 7. *You argued in your paper that a further major advance in our long-term care system will depend on integrating some of the many funding streams from which those services are paid. Prior to accomplishing that--and that is surely a major project--does the fact that in some states the state units on aging and the area agencies on aging are already deeply into case management and assessment mean that the act as it stands is satisfactory? How can the addition of language in the Older Americans Act move other state agencies in the direction of creating consolidated long-term care funding?*

Although front-running state units and area agencies are already heavily involved in case management and long-term care, the entire aging network would benefit by a clear statement that supportive services (i.e., long-term care services) in general and case management in particular are the proper interest of the area agencies under Title III.

Otherwise the area agency is at peril of neglecting specified services to undertake services not emphasized in the act and many will be deterred.

Three changes in the Older Americans Act would facilitate the area agencies in long-term care programs: (1) specific indication that supportive services are at the heart of Title III mission, with existing services given as examples so that they will not be presumed to constitute an all-inclusive list; (2) permission for area agencies to allocate funds more flexibly between Title IIIB and Title IIIC and between Title IIIC1 and Title IIIC2 within Title IIIC; and (3) explicit permission for area agencies to do direct practice of case management (which should not be construed as a service in the usual sense). The first two changes afford state units and area agencies authority and flexibility to develop responsive long-term care plans to meet assessed needs as they arise (without neglecting traditional service areas). The third addition recognizes that, although area agencies should not generally do direct service, case management is a mechanism to allocate, plan, authorize and/or fund service rather than a service itself. Under some models of case management, the delegation of case management to service providers would actually give an unfair and inappropriate control over service to particular community agencies.

The question of consolidated funding is different. The Older Americans Act cannot unilaterally bring about consolidated long-term care funding. Changes are needed in the Social Security Act to permit such a consolidation. Perhaps considerations might be given to specifically encouraging state units and area agencies to explore with relevant state agencies the potential for consolidated funding.

8. *You indicate that developing community-based services seems to have no immediate effect on use and costs of nursing homes. What is your view on the potential for case management and assessment systems for controlling the use and cost of community-based services?*

I would like to clarify that case management could have an immediate effect on appropriateness of nursing-home use through a better process of making admission decisions. It seems, however, that the potential for controlling nursing-home use and cost in the aggregate would be felt as a downstream advantage. After community-based services were well established and accepted, the growth of the nursing home sector could be more deliberately controlled.

Community care and case management do not automatically reduce nursing home costs. They do, however, provide a climate in which deliberate action to reduce nursing supply is politically and socially more acceptable. In contrast, case management has an immediate likelihood of controlling the use and cost of home-based services in contrast to their likely expansion if the service benefits were introduced without the case management. Home-based services are intrinsically more flexible than is institutional service. They can expand and contract to meet demand. The community service field has no analogue to the pressure to fill a nursing-home bed. If one agrees that community long-term care services are needed, however, a case management system is also needed to assume appropriate distribution of such services within the constraints of available resources. The case management system must ensure that they are offered as a public benefit only in the instance of and to the extent needed for assessed functional problems.

9. *If area agencies were to be given priority in being designated the local "case manager and assessor," what steps would have to take place prior to this designation, i.e., in terms of state planning and community reorganization? What provider groups would be likely to be disaffected by this strategy? Would changes in other federal law be necessary?*

For area agencies--or any other agency--to be designated the local case manager, community agreement would be needed on the scope of that case manager's authority and the range of services that would fall under his/her purview. In the most vigorous systems, agreement would be needed for the case manager to make designations of eligibility for SNF and ICF institutional care. Memoranda of understanding would need to be developed among the relevant agencies. The case manager would need real authority and at the same time an orderly appeal process should be developed. An effective and reliable assessment system would be needed along with appropriate training for the case managers. Organizations like the AoA-funded Long-Term Care Gerontology Centers would be appropriate resources to assist in developing assessment tools and in training case managers.

Any new system challenges the equilibrium in a community and may, especially initially, disaffect provider groups. The nursing-home industry would be concerned about the advent of case management because of its potential to divert admissions and alter the case mix in nursing homes toward more severely ill persons. However, there is reason to hope that this objection would be short-lived because case management would not threaten the full use of existing homes that meet quality standards. Home health agencies may also resent case management because of a view that professionals in the home health agency are best equipped to decide how much service should be authorized. In the Canadian provinces we studied, such problems were handled by efforts to distinguish operationally between professional decisions about modalities of care and a case manager's more general decisions about the level and type of care needed. Finally, discharge planners in hospitals may perceive that case managers are assuming some of their traditional roles. Please note that these groups have the same potential for disaffection regardless of whether the case manager is an area agency, a public health department, or a welfare worker. The problems can be resolved through careful planning, involvement of interested parties in the community, and efforts to address their legitimate concerns.

10. *Am I correct in assuming that a proper case management system as you describe it so well in your statement would be expensive in the context of the budget of area agencies on aging?*

Such a system would definitely represent a new, substantial cost if the entire expense were assumed by area agencies. It is not clear, however, that area agencies should bear the full or even the major cost of case management in a fully operational consolidated system. The case management system will, after all, result in savings under Medicaid and the Social Services Block Grant (Title XX). There are already examples of a state Medicaid agency contracting to area agencies for specific assessment and case management tasks.

The cost of case management will, of course, depend on the size of the planning and service area. In some rural counties in California, for example, it is possible to enumerate the people at risk for long-term care, and a single case manager could readily manage the entire caseload of persons using home health and homemaking services or living in board and care homes and still assess new applicants as needed. In large, urban areas, several new case manager positions would be needed.

The cost also depends on the size of the caseload. British Columbia's case managers often have caseloads of 250 or more, which proved too large to permit proper monitoring. A caseload well under 100 would seem more appropriate. Cost also depends on the personnel patterns. Although it can be enriching for a case management staff to include persons of various disciplines (e.g., social workers, nurses, and others), team case management is inefficient and not indicated as a routine matter. If we can imagine a modal agency serving 300 long-term care clients at any given time, the costs of case management would likely be about $80,000.

11. *Assuming only modest future growth in Older Americans Act programs, are case management services expensive enough so that mandating them would necessarily mean that fairly important resources would have to be diverted from other Title IIIB or IIIC programs?*

Yes, it does follow that case management would consume some of the resources presently used for other services under Title III although, as mentioned already, it would not be necessary for the Older Americans Act to bear the entire burden of case management in an operational system. Some of the needed reallocation may be achieved painlessly by scrutiny of the efficacy of existing programs. Not only will resources need to be diverted to case management (if they cannot be raised through contracts with other agencies) but internal reallocation of contracted services may also be necessary to ensure targeting on the needs of the frail and disadvantaged elderly.

12. *You have argued that the case management function and the service provision function should be distinct as they are actually carried out. Given that many triple-a's at least say that they are engaging in case management, is this separation important enough to be required in the Older Americans Act?*

Although many area agencies indicate they have activities related to case management, the effort devoted to such activities may well be minimal in some instances. Before an agency can invest substantial resources in such an effort, it needs reassurance that this use of scarce resources is sanctioned. Perhaps the most important clarification in the Older Americans Act bearing on this issue is the need for permissive or even persuasive language to encourage area agency personnel to do case management directly if that is the model that the state or locality develops.

13. *Some people are concerned about quality assurance in home and community-based care. William Weissert, at our July hearing, cautioned that a large increase in home care services could bring new hazards and dangers. One of our later witnesses will propose that a national private association certify home care providers. How would you accommodate the need for quality assurance in the local long-term care systems you envisage?*

I agree with Dr. Weissert that home care programs are particularly vulnerable to lapses in quality. Because of their decentralized, "hidden" nature, their quality is hard to monitor. Accreditation may be a step forward but certainly does not in itself guarantee quality. If a public entity purchases services rather than providing them directly, the obligation to monitor the quality and appropriateness of those services is inescapable. Recently the city of Vancouver, British Columbia, began requiring specific quality assurance plans from any agency receiving a homemaker contract. Items such as personnel training, bonding, written policies on handling complaints and so on were included in the expectations. The case management agency surely has an obligation to assure that services ordered have actually been provided and that the clients are being treated humanely. It could monitor these aspects of quality through spot checks by telephone and periodic surveys of the opinions of the clientele. The separation of the case management function and direct service delivery at least provides a channel so that elderly persons can make complaints if service is irregular or of low quality.

Senator Grassley. Dr. Patten.

Dr. Patten. Mr. Chairman, I appreciate your invitation to testify before this subcommittee on this important topic.

The complexity of long-term care hampers program and policy development. It is difficult for decisionmakers to understand the system, agree upon common values and system and client goals, define the nature and extent of public and private responsibility, and develop management, service delivery, and financing strategies for addressing identified needs and problems.

The current economic mood and Government strategies emphasize cost containment and cost-cutting rather than expansion. Although available evidence is mixed, the likelihood that substantial cost savings will be realized through alternatives to nursing homes is certainly not clear. One question raised is whether these services are actually a substitute for institutional care or whether they are an "add-on." Discussions often ignore the heterogeneity of clients within various long-term care settings with regard to functional disability and other risk factors.

Questions are also raised regarding the quality and effectiveness of nursing home care relative to the cost. As community-based care expands, similar questions will likely be raised regarding these services. Indeed, quality assurance issues will be more difficult to address for noninstitutional care, especially when it is provided in a person's home.

Before I comment on a few long-term care problems on issue areas and the aging network's involvement with them, I would like to make three specific points regarding long-term care.

First, a single long-term care system does not and will not exist. Systems vary substantially within and across States. While we may move toward some greater uniformity, diversity will and should remain. There is no one answer to how long-term care should be organized and financed which can be applied universally. We need to continue to explore and evaluate alternative organizational and management structures, service delivery approaches, and financing mechanisms in order to better understand their relative costs and effectiveness.

Second, while persons aged 65 and over and especially 85-plus are high users of long-term care, there is substantial need for long-term care among the under-65 population. As the long-term care system evolves, it is essential that planning, policymaking, and program development cut across age and disability groups. Although the needs and services may differ and vary to some extent, many commonalities exist and should be capitalized on.

Third, with the aging of the older population, long-term care users are more likely to be very old, disabled, and in poor health. These individuals will often require a combination of acute health care and long-term care services. These changes can currently be seen within the nursing home population. Further clarification is needed on the relationship between long-term care and acute care services.

The aging network has and can continue to exercise an important role in the shaping of the long-term care system. This effort, however, should continue within the context of developing a service system to address the identified needs of all older persons.

The State Units on Aging and Area Agencies on Aging comprise a heterogeneous group of agencies that vary widely in terms of organizational structure, responsibilities and authority, political power, staffing and funding sources and levels. There is also variation in the environments in which they operate. While there is a certain richness inherent in such diversity, this variation also makes it difficult to prescribe the nature of roles and responsibilities for long-term care. What it seems to suggest is a degree of flexibility which allows for activities by the aging network that best match the particular needs and environment of each locality.

Given this context, I would now like to comment on a few specific long-term care problem areas and suggest some points of involvement for the aging network.

A recurring problem encountered in long-term care is the dearth of policy-relevant data. Data are limited on current and potential users of long-term care, the types of service providers, the types and quantities of services provided, the associated costs, and the distribution of the cost burden. Better understanding is needed of client characteristics and related factors which place persons at high risk of requiring long-term care and of the relationship of these risk factors to service utilization patterns, and therefore to cost.

While there have been some important efforts to correct this situation, much remains to be done. This is an important area where the aging network can focus its activities.

A variety of public, nonprofit and proprietary agencies and organizations are involved in long-term care. Recent developments suggest that hospitals, hospital and health care chains, and large insurance companies will play an increasingly active role in the provision of long-term care. Eventually, large insurance companies may, through the acquisition of hospitals, hospital chains, and corporations, be in a position of providing insurance as well as services. The aging network can help track and monitor these developments as well as serve an advocacy role in insuring responsiveness to local community needs.

In a sense, the aging network can play a significant role in maintaining the integrity and legitimacy of a diversity of long-term care service arrangements. While major providers of long-term care in the future may include large corporate structures, there still remains a network of local public and private agencies, organizations, churches, which will continue to provide long-term care. The aging network can help these local providers "hold their own" by helping them organize, coordinate and adjust the use of their resources in a manner responsive to these changes.

A critical element of the long-term care system is the informal support network of family, friends and neighbors. Public long-term care policy has often not acknowledged nor been responsive to these caregivers and the substantial quantities of services they provide. There should be increased efforts to develop approaches which enable existing caregivers to sustain their caregiving activities as well as strategies which provide incentives to potential caregivers.

Policies and programs for enhancing the provision of informal care include financial strategies such as tax incentives and cash transfers and service strategies which recognize that caregivers frequently experience substantial physical, emotional and/or financial stress. Services to the disabled older person such as adult day care, companion service and home care can help provide some relief to the caregiver. Support can also be provided through caregiver support groups and caregiver training and educational programs.

It is suggested that the Older Americans Act encourage the aging network's active involvement and use of OAA resources to explore approaches which help communities better organize, coordinate and sustain the caregiving activities of the informal support network and quasi-formal network of volunteers as a complement to formally provided services.

Long-term care is characterized by fragmentation with regard to management, service delivery and financing. Frequently mechanisms are not available to work with the older person and her/his family to assess need, identify the appropriate mix of services required, arrange for services and monitor service provision. Case management is one mechanism suggested to address this problem. Models of case management vary along a number of dimensions including program objectives, activities or functions performed, clientele served, nature and extent of responsibility and authority over service provision and financing, and the extent of responsibility to the clients served.

Thus, a range of case management models exists. Currently, however, there is limited evidence on the relative costs and effectiveness of these models.

It is important to keep in mind that not all long-term care users and family members want or need case management services. Indeed, the proportion of persons needing the rather intensive levels of case management is probably relatively small.

While case management in its various forms is no panacea, it may be one useful means of helping people better match their needs with appropriate services and settings. The development of case management systems, however, should proceed in a measured, cautious manner lest we create overprofessionalized, inflexible, and costly structures. SUA's and AAA's should continue to be involved in the planning, development, monitoring, and evaluation of case management systems. The role they assume in this activity will vary within and across States.

Information is one of our most costly and valuable resources. In the rapidly expanding field of long-term care, it is essential that decisionmakers have ready access to current information on management, service delivery, quality assurance, and financing issues. An important role that the aging network can perform is to pull together, synthesize and disseminate information on various national, State, and local initiatives in these areas, for example, long-term care insurance, home equity financing of long-term care, voluntary long-term care accounts, preadmission nursing home screening programs and other related activities.

The OAA aging network also has a major role in ensuring that information on long-term care services is available and accessible to the elderly and their families regardless of what part of a State they reside in.

The bulk of long-term moneys does not flow through the Older Americans Act. In some States, the aging network has direct control of resources from medicaid, the social services block grant, and other public programs. Where this is not the case, the aging network should be actively participating in the planning, program and policy development, evaluation and resource allocation decisions related to these public programs. In addition, the aging network should monitor closely the impact of new initiatives in reimbursement and financing, for example, State nursing home reimbursement strategies such as case-mix reimbursement, and the new diagnosis-related group reimbursement system for hospitals. The effect of this latter Federal initiative on long-term care may be substantial.

The OAA network has been and should continue to be actively involved in long-term care policy and program. The nature and extent of that involvement will vary due to the diversity within the aging network. While these activities are an extremely important component of its work, all of the aging network's energies and resources should not be targeted on long-term care. The language of the act should be changed to reflect the increasing and important role of the aging network in the development of long-term care systems.

Mr. Chairman, this concludes my prepared remarks. I will be happy to respond to any questions.

Thank you.

[Responses of Dr. Patten to questions submitted by Senator Grassley follow:]

QUESTIONS FOR DR. SHARON PATTEN FROM SENATOR CHARLES E. GRASSLEY

1. Let me ask if I see a certain difference here in your treatment of how the Older Americans Act network should approach this long-term care area. Dr. Patten, you seem to be concerned with preserving some of the Older Americans Act's traditional functions such as advocacy, coordination and planning, and you advocate long-term care activities of a kind that I guess you would say are in keeping with the nature of the Older Americans Act network. Dr. Kane, you seem to be willing for the Older Americans Act network to move fairly substantially into this area, perhaps undertaking a major change in direction in the process. Have I understood your presentations correctly?

While I do not suggest a maintenance of the status quo, I also do not think it appropriate to mandate or require that the bulk of current Older Americans Act resources be targeted on long-term care and on the development of case management systems. I would suggest, however, that an increasing focus on long-term care be given under the Act and that this priority be incorporated into specific language in the Act.

In addition to its role in long-term care, I think that the Older Americans Act serves a legitimate function when a portion of its resources are used to help older people who may not currently need long-term care, but who are experiencing significant changes and losses (economic, social, physical, psychological, etc.) that often accompany aging.

2. I take it from your treatment of case management that you do not think that it would be a good idea if we required area agencies on aging, or state agencies on aging for that matter, to develop case management systems?

Yes, that is correct. I am certainly not against the planned development of case management systems, but given the level of existing resources under the Older Americans Act along with the other reasons I noted in my testimony, I hesitate to suggest an all out effort in this area. What might be a middle ground would be to establish case management as one priority area that State Units on Aging and Area Agencies on Aging are to address. The aging network along with other agencies and organizations would explore the appropriate role of case management in their particular state and/or localities. In some situations, the focus might be on examining the feasibility of a case management system, while in others activities might center on how to further refine an already operational system. The scenarios will, of course, vary across the states as will the nature and extent of the aging network's involvement and use of resources.

3. I, too, am interested in the effect on older people of some of the developments you mentioned in your statement, such as the new diagnosis-related group reimbursement system for hospitals. Now, the Ombudsman people tell us that they already have enough to do in keeping track of what is going on in nursing homes and cannot take on additional responsibilities.

Is the network going to have the capacity to monitor these new initiatives and how would they do it?

It may very well be the case that staff under the Ombudsman program already have too much to do and to ask more of them without additional resources would severely undermine their current efforts and effectiveness. The aging network can, however, in close collaboration with other agencies, organizations, consumer groups, universities, etc., monitor new initiatives such as the diagnosis-related group reimbursement system.

Various approaches can be pursued including research projects of varying size and scope, public forums which provide a place for discussion and debate, and which increase awareness of the issues involved, study groups which examine the particular policy or program initiative, monitor its implementation and develop a timely and widely distributed report(s) of its findings and recommendations. Also, the mass media can be involved, e.g. by producing small, focused studies on specific issues and reporting the findings to the general public.

These are only a few approaches to monitoring and responding to these program and policy initiatives. It is important that such efforts involve individuals, organizations and resources from the public and private sectors. In some instances, the aging network would play a lead role, while in others, it would serve more as a catalyst.

4. You both spoke very eloquently about the importance of families in providing help for dependent older people and I think both of you are exactly right in emphasizing the importance of preserving the family as the major support for these older people. It's sometimes suggested by people who concern themselves with these matters that introduction of formal services can lead families to reduce the help that they give.

Do you think that this is a potential problem as more long-term care services develop, or would it be a problem if we were to provide tax credits and that kind of thing which might encourage families to begin to purchase care for their older relatives.

Yes, in some instances families or other informal caregivers might reduce their efforts, that is, substitute some of the care they provide for formal agency services. I think it is important to note, however, that if such a reduction in informal care occurs, it may serve some positive purposes. In some situations, regular relief or respite from overwhelming caregiving responsibilities might help informal caregivers maintain their key caregiver role over a longer time period. In others, we have to be careful that we are not "penny-wise and pound foolish."

Some evidence suggests that the introduction of formally provided services does not result in any significant decrease in informal caregiving. Also, in some instances, informal caregivers may reduce their efforts in areas where a formal provider can pick up some of the care, and then assume added responsibility for other services and care. Thus, some redistribution of the types of services provided may occur.

Currently, however, there is little evidence on what the direction or magnitude of incentives/disincentives to informal caregiving might be if various direct or indirect financial (e.g. refundable tax credits, monthly allowances) or service strategies were implemented.

The development of public policy and program in long-term care has generally not acknowledged nor been sensitive to the key role of informal caregivers. For the most part, it has either ignored these caregivers or has operated from a negative stance based on the fear of a wholesale reduction in their caregiving efforts, rather than on a positive approach which works at supporting and complementing the efforts of these caregivers.

While I think that the question of whether informal caregivers will reduce their efforts if community-based care becomes more available is important, I would rather see more attention being given to how we can better support and encourage the informal caregiving that already exists. Maybe it is a slightly different way of looking at the same issue, but I think it is a much more positive and potentially productive venture.

A variety of financial and service strategies for supporting caregivers have been proposed. As this point in time, there is limited evidence on their costs and effectiveness. We need to pursue more rigorously efforts to explore, test and evaluate these strategies.

5. One of you pointed out, I think it was Dr. Patten, that in some states state units on aging and area agencies on aging have direct control of resources from medicaid, the social services block grant, Title III and other public programs. And we heard last July in our hearing on long-term care that in several states the Older Americans Act network is already deeply involved in long-term care activities, including case management.

If some state units and area agencies are already doing very extensive work in long-term care, why do we have to change the Older Americans Act? Wouldn't this state of affairs seem to imply that the Act is already flexible enough to allow this kind of activity if the states and localities want to get into it?

The Act does provide a certain degree of flexibility. I have noted in my testimony a few changes which would increase this flexibility. I would also suggest that more specific language which indicates an increased priority on long-term care activities be incorporated in the Act. This would help underscore and legitimize the aging network's activities in long-term care.

Within this context, a focus on activities related to exploring the feasibility and/or development and implementation of case management systems could be included as I noted in my response to an earlier question.

6. Some people are concerned about quality assurance in home and community-based care. William Weissert, at our July hearing, cautioned that a large increase in home care services could bring new hazards and dangers. One of our later witnesses will propose that a national private association certify home care providers. How would you accomodate the need for quality assurance in the local long-term care systems you envisage?

The issue of how to ensure quality in non-institutional long-term care is only beginning to be addressed. The opportunities for abuse and fraud are probably considerably greater for community-based care than for institutional care.

On the institutional side, efforts to measure quality have focused on inputs (e.g. buildings, staff) and to a lesser degree on the care process itself. There has been only limited activity on measuring the outcomes of care. Defining and measuring quality in the care process is difficult just as it is to specify and measure outcomes which can be related to the care process. It is likely that as community-based services expand efforts to measure quality will increase substantially. We are only beginning to struggle with this issue.

Licensure or accreditation of individual providers or professionals is one possible approach that has been used on the institutional side and has in most instances come at the request of the professionals/providers. Such an approach can help insure that certain educational and/or work experience requirements have been met, but it does not necessarily ensure that a quality of care process is provided or that care outcomes are achieved. Rather, professional licensure and accreditation focus on input measures of quality.

Licensing and certification processes for home care agencies and organizations also serve the same basic purpose. We may need to have some combination of both. Of course, any efforts to ensure compliance with a set of standards is costly.

In order to get a handle on the quality of the care process, it may be necessary for government to institute review processes for non-institutional services similar to the Periodic Medical Review (PMR) and the Independent Professional Review (IPR) for skilled nursing facilities and intermediate care facilities, respectively. Such activities might be performed on a sample basis or focused mainly on the most vulnerable portion of the home care population. After a track record has been developed, reviews might also be focused on those agencies and/or providers whose quality of care is consistently in question. Also, efforts should focus on obtaining feedback from consumers of care and as appropriate from family members on the overall quality of the care provided and on their satisfaction with the services.

In addition, governmental or non-governmental mechanisms could be established at the state and/or the community levels which serve ombudsman and advocacy functions. For example, in Minnesota a non-governmental organization (Nursing Home Residents Advocates) plays a key advocacy role. Staff work not only on behalf of individual nursing home residents, but also address state and local policy and program issues affecting nursing homes and long-term care in general. Similar types of organizations might be effective with regard to non-institutional care.

Also, it seems that there should be widely publicized and readily accessible mechanisms (e.g. a hot line) for clients, family members, concerned citizens, to report situations where poor quality care, provider abuse, fraud, etc., may be occurring. Such mechanisms need to ensure that responses to such reports are timely and effective.

7. You emphasize the importance of getting a handle on the distribution of risk factors, service utilization factors and cost patterns in the general context of the need for better data about long-term care. I wonder whether the long-term care gerontology centers which the Administration on Aging is now supporting could not help with that sort of thing?

Although I have limited knowledge of the current activities of the long-term care gerontology centers, I would think that they should be involved in such an effort. The State Units on Aging and the Area Agencies on Aging can also play an important role in this matter at the state and local levels by working with other agencies and organizations to modify existing or develop new data bases which provide policy and program relevant information in a timely and readily accessible fashion. It is also important that they explore ways of linking existing data sources for research and policy analysis purposes.

Senator **Grassley**. I think I will submit my questions in writing to both of you, and move on to the second panel.

Thank you very much.

For our second panel we first have Patricia C. Schramm, who is going to represent the National Council of State Public Welfare Administrators. She comes to us from Delaware, where she is in charge of the Delaware Department of Health and Social Services.

We wanted Ms. Schramm so that we could find out how someone who administrates a number of important health and social services programs, in addition to the Older Americans Act, feel about some of the matters we are considering today.

We also have Dr. Richard Rowland from Massachusetts where he is secretary of the Department of Elder Affairs, and presides over the State aging network, which is very involved in long-term care.

Ms. Wilda Ferguson is director of the Virginia Office on Aging, and today will speak also for the National Association of State Units on Aging, which has given some thought to these issues.

So would you proceed in the way that I introduced you, please?

STATEMENTS OF PATRICIA C. SCHRAMM, CHAIRPERSON, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS OF THE AMERICAN PUBLIC WELFARE ASSOCIATION AND SECRETARY, DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES; DR. RICHARD ROWLAND, SECRETARY, DEPARTMENT OF ELDER AFFAIRS, STATE OF MASSACHUSETTS; AND WILDA FERGUSON, COMMISSIONER, DEPARTMENT FOR THE AGING, COMMONWEALTH OF VIRGINIA, NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Ms. **Schramm**. Thank you, Mr. Chairman. I welcome the opportunity to appear before you this morning to represent the views of the National Council of State Public Welfare Administrators on this topic.

I am Patricia Schramm, the chairperson of the National Council of State Public Welfare Administrators, which is a component of the American Public Welfare Association, and as you indicated, Secretary of the Delaware Department of Health and Social Services.

The National Council of State Public Welfare Administrators is composed of the public officials in each State, the District of Columbia, and the U.S. territories, charged with the responsibility for administering publicly funded human service programs. This includes a broad array of services to the elderly.

Currently, 22 State human service agencies, including Delaware, are also designated as the State agency on aging, and thus, have administrative responsibility for the Older Americans Act. In the remaining 28 States and the District of Columbia, the responsibility for administering the act lies with a free-standing department on aging. Although not every member of our council administers the Older Americans Act, we carry responsibility for the other key programs that provide long-term care to the elderly: SSI, medicaid and the social services block grant.

The National Council of State Public Welfare Administrators strongly supports reauthorization of the Older Americans Act. Although not advocating major revisions to the act, the State human services administrators would like to recommend, for this committee's consideration, a number of changes which we believe will better enable us to coordinate and link all available resources to meet the needs of the ever growing elderly population. The changes we recommend would, as a whole, develop more fully a continuum of care concept within the act and enable more effective targeting of scarce resources on those older persons with the greatest social and economic needs.

In long-term care, the development of alternatives to the traditional medical model of long-term care is a dilemma that all levels of government are currently striving to resolve.

In recent years, a shift in focus has occurred as we have come to realize the value, both in social and in economic terms, of preventing institutionalization and preserving self-sufficiency for the elderly at risk. The Older Americans Act—with its goal of developing community-based support systems to help older Americans remain independent—was one of the early pieces of legislation to recognize the value of supportive services in lieu of institutionalization.

Today, the largest Federal program providing supportive services for the elderly is the title XX Social Services Program. States have long utilized title XX funds for the types of community and home-based supportive services which often mean the difference between independence and institutionalization. While title XX services are provided to all age groups, in 1980 figures show that services for senior citizens accounted for approximately 35 to 40 percent of total expenditures.

With the passage of the 1981 reconciliation bill, Congress also recognized the value of allowing States to provide "nonmedical" services through medicaid instead of only through title XX or title III of the Older Americans Act. States may now seek waivers to provide home and community based care services for individuals who, without such services, would be placed in a nursing home or otherwise institutionalized. At last count, 46 States had applied for 100 waivers for services to the elderly and disabled under this program. As this experience shows, there is strong interest by the States in working out new, more effective, rational ways to provide long-term care.

The ever-tightening budget constraints within which we must live, coupled with greater administrative flexibility, have enabled, and often forced, the development of needed linkages between medical and social services, especially with respect to long-term care for the elderly. We have also discovered that given the complexity of individual needs and the variability of community resources, there is no one approach to long-term care that will work everywhere.

While State administrators do not have all the answers regarding the most effective and efficient long-term care approaches, our experience has revealed the importance of several factors. We would like to first offer the subcommittee a number of points about long-term care policy in general, and then some specific recommendations for how the Older Americans Act can be amended to assist States in providing individualized, decent quality, cost-effective, long-term care for the elderly.

First and foremost, States should serve as the primary administrators of long-term care. States have the experience, knowledge and access to the information about the available resources, and the specific needs within a State which are necessary in developing appropriate long-term care programs. Local human service agencies and area agencies are, of course, valuable links in any long-term care network. It is the States, however, that are best prepared to serve as the focal point.

Second, States should be provided maximum flexibility to develop such alternatives. One of the distinct advantages of having States in the lead in developing new, better approaches is that there are as many different approaches being examined as there are States involved.

Third, the Federal Government must be prepared to adequately support programs serving the elderly, which is the fastest growing segment of our Nation's population. Human services administrators across the country have seen the costs of serving the elderly soar in recent years, as the number of older people seeking care has increased. Current demographic trends reveal that the elderly will become an even larger part of the total population by the year 2000. Long-term care programs should and must exist within an overall national policy framework, be backed by a sufficient Federal financial commitment.

I would like to turn now to a few specific recommendations about the Older Americans Act.

First, we believe improvements should be made to strengthen service systems for the elderly and provide for a continuum of care.

Because delivering services to the elderly is growing more complicated and involves coordinated community-based options as well as institutional care, and because of the complexity of multiple funding streams and programs all targeted to different treatment components, there is a clear need for a more coordinated, systematic approach to service delivery. This approach should be based on a continuum of care concept and should include the assessment of individual needs, wholistic case management approach, and the availability of appropriate services in the home or community or institution, whichever is most appropriate.

In order to achieve this, we recommend that the act be amended to include in title I, as additional objectives, the development of a systems approach to service delivery that is flexible in meeting the needs of the individual and the community, as well as the development of a full continuum of care approach to assure that support is provided to individuals and families in the most appropriate setting.

We also endorse the recommendations of the National Association of State Units on Aging that the act be amended to include in title III language which would expand the role of State units on aging and area agencies on aging in the development of a coordinated long-term care system.

Our second recommendation is to amend the act to more effectively target available resources to prevent or delay institutionalization and to promote utilization of funds for a total continuum of care. Age alone should not be the sole eligibility criterion for most of the Older Americans' programs. Instead, eligibility should be based on those factors that most jeopardize independence. These factors should be determined either within each State or perhaps, more appropriately, within substate areas. Factors might include fraility, age, race, income isolation, and health.

The National Council recommends that specific language be added to title III requiring States to analyze the factors causing individuals to be at risk and to demonstrate how resources are being targeted to reduce these risks. In addition, the issue of identifying at-risk elderly groups and appropriately serving these groups should be a clear research priority within title IV of the act.

Third, State administrators recommend that the act be amended to give States the option of implementing a fee or cost-sharing system for specific programs within title III of the act.

An example of a service for which a fee might be charged is home-based care. As it now stands, an elderly person receiving home-based care services under the Older Americans Act may not be charged a fee regardless of income. However, a less wealthy neighbor receiving the same service through title XX could be charged an income-based fee. While we believe States should be given the option to institute a fee or cost-sharing system, this would not negate the State's responsibility for planning and advocacy for all of its elderly citizens. States that implement such a fee or cost-sharing system should be required to demonstrate strong public participation in setting the fees, to ensure that services are provided equitably to all those in need, and to disclose the amount of funds received and how they are utilized. In addition, the Administration on Aging should be required to develop an evaluation mechanism for States that implement a fee or cost-sharing system.

Fourth, we recommend retaining the flexibility available to States under title XX, the Social Services block grant. We recommend strongly that Congress reject any attempt to earmark title XX funds for long-term care services or other services to the elderly. States should retain the authority to allocate title XX funds according to State-established priorities. This flexibility allows, but does not require, States to utilize title XX funds for the provision of services to the elderly.

As our fifth recommendation, Human Service administrators urge Congress to amend titles II and III of the act to require coordination at the Federal, State, and local levels between Older Americans Act programs and the means-tested programs which serve the elderly, such as title XIX medicaid and title XX.

To access additional funds to serve the elderly and to develop a truly wholistic approach to a continuum of care, it is necessary to coordinate Older Americans Act funds with other, in particular, means-tested programs serving the elderly. This coordination must begin at the Federal level if it is to be truly successful in the local community.

Sixth, the State administrators recommend that the act provide for an established proportion (with an established minimum dollar level) of the total funds appropriated by Congress for title III to be allotted for State administration in lieu of the current administrative cost provisions in the act. As a result, administrative funds have not kept pace in recent times with inflation or with the increased responsibility of the State units on aging.

In proposing an established portion for administrative costs, we do not recommend a set percentage or minimum level at this time. Rather, we propose that the administration on aging support a study to determine the appropriate proportion for State administrative costs.

We recommend continuation of the current prohibition against direct service delivery by State units. This prohibition should be lifted only if direct provision of services is necessary to assure an adequate supply of a particular service or to ensure the quality of the service provided.

Last, we support the retention of the current funding streams within title III (III-B Social Service and III-C Nutrition Services) and an increase in the flexibility now provided to States to determine the actual allocation of resources within title III. The State and local administrators recommend that this flexibility be increased by expanding from 20 percent to 25 percent the amount that can be transferred between titles III-B and III-C.

There are several other recommendations for changes to the Older Americans Act which have been adopted by the Council, since however, this meeting is on long-term care, I think they are a part of the written testimony, and I will not go over them at this time.

Thank you very much

[Responses of Ms. Schromm to questions submitted by Senator Grassley follow:]

QUESTIONS FOR MS. PATRICIA SCHRAMM FROM SENATOR CHARLES E. GRASSLEY

1. I want to start with a question on targeting under the Older Americans Act. This is a matter we went into in some detail last November in our hearing on targeting. At that hearing we heard from the Federal Council on Aging, and they maintained that the states should have considerable discretion in determining how the "socially and economically most needy" elderly, which is the language of the Act, are defined.

Is it your position now that the states should have a free hand to define how this socially or economically most needy term is defined, or are you saying that the Federal government should require states to target individuals at-risk of institutionalization and then have the freedom to define who these people are?

2. You are interested in the coordination of the Older Americans Act programs with such other programs as Title XX and Title XIX.

Hasn't it become much easier with the block granting of Title XX and the Section 2176 waivers to do this? And what else is needed?

BEST COPY AVAILABLE

STATE OF DELAWARE
OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
NEW CASTLE, DELAWARE 19720
PHONE (302) 421-6705

February 24, 1984

The Honorable Charles E. Grassley
Chairman, Subcommittee on Aging
U. S. Senate Committee on Labor
and Human Resources
Washington, D. C. 20510

Dear Senator Grassley:

This letter is in response to your letter of February 7 requesting that I respond to two additional questions for inclusion in the hearing record on "Long-Term Care Under the Older Americans Act."

1. APWA's position on targeting is that the States should have a free hand on defining who is most "socially and economically needy." States should also have the option to charge fees for certain services based on individual income which will also help to target who receives services. APWA does not support a means test to determine a fee service but a fee schedule which would be developed around different income levels.

2. It has been much easier to coordinate the Older Americans Act programs with the block granting of Title XX and the Section 2176 waivers. We do not believe that the Older Americans Act funds should be block granted. The Section 2176 waivers have been extraordinarily useful and consideration should be given to institutionalizing these waivers. In response to what else is needed, it would be helpful if Congress encouraged further coordination between programs serving the aging. In those states in which Adult Protective Services and the Office on Aging are in different state agencies, there is often very little or no coordination between the two aging programs. Although coordination should not be Federally mandated, it could be encouraged via some type of Congressional expression of intent.

I appreciated the opportunity to testify before the Subcommittee on Aging and hope this additional information will be valuable to the Committee.

Sincerely,

Patricia C. Schramm

Patricia C. Schramm
Secretary

sm

cc: Eleanor L. Cain, Director
Division of Aging

Senator **Grassley**. Dr. Rowland?

Dr. **Rowland**. Mr. Chairman, thank you for the opportunity to present my views on long-term care on the Older Americans Act.

Services to seniors are a major priority of State government in Massachusetts and have been for 10 years. 12.7 percent of our population is age 65 years or over. An estimated 6.5 percent of our elderly presently reside in nursing homes and rest homes. Another 43,000 seniors receive social services through our State-funded home care program, about approximately 5.3 percent of the State population.

Governor Dukakis and our State legislature have committed $87 million for social and nutrition programs this year and $94 million in State money has been requested for next year.

By contrast, we receive just under $17 million in title III for similar programs. Our State programs operate through 27 home health care corporations, which are nonprofit agencies. The State has established 23 AAA's. In 20 areas the Home Care Corp. has been designated as the AAA. Three area agencies operate independently of the home care system and one of these is a local governmental unit.

I favor the concept of a single entry point for community care. When our home care system was established providing social services was a major goal. Today in Massachusetts we still lack the integration between health and social services. An efficient system must have that integration.

The Older Americans Act could make a substantial contribution to the single community agency concept by stressing the need for an integrated system. A channeling demonstration program has helped us serve frail elders who are eligible for nursing home care but choose instead to remain at home. This program has demonstrated the importance of social services for keeping people at home. Social services comprise 80 percent of the services used by channeling clients while health services comprise 20 percent of expenditures during the 1st year of operation of the channeling program.

The program has demonstrated the importance of alternate services on nights and weekends. Over 50 percent of channeling clients receive services during nights and weekends.

A moderate centralization model works well in Massachusetts. Selecting the designated agency however must reflect experiences and conditions that vary State by State. We need to examine the implications of locating advocacy and delivery or direct service delivery in case management in the same agency.

The act should specify the functions that might be located in a designated long-term care agency or the criteria to be used in designating an agency. But States should have the flexibility to make designations that reflect variations in the systems among the States.

There are several other issues which are crucial to the operation of a community-based system. First, there can be no effective Federal mandate without an adequate financial commitment. The structure without the funding will leave a beautiful but empty house and will undermine public support for the program. The Older Americans Act is a good vehicle to shape the direction of long-term care. It embodies the commitment to community care that is absent from medicaid and medicare.

Medicare is heading in the wrong direction. Hospital cost containment programs are sending elderly people back to the community sooner and sicker. Yet medicare only reimburses home health care on an intermittent basis and it fails to pay for many services.

Today's patients need daily care and a program to pay for it. It makes little sense to expand the long-term care system under the Older Americans Act if it is undermined by cuts in medicare and medicaid.

The second key issue is the linkage between community and institutional services. To care for people in an appropriate setting, both institutional and community providers must coordinate assessments, referrals and services.

The absence of a controlling mechanism to screen institutional placements leaves a major weakness in the two systems of care. Each has operated independently of the other.

Support for expanding community care must be tied into attempts to limit the growth of institutional services. If the supply of alternative services expands in an area, there must be a reduction in the planned growth of institutional care. We need a process that offers community care to people for whom it is appropriate and we must balance the growth of community and institutional services. In the end they are competing for the same money. The Older Americans Act can serve as a mechanism for creating the Federal commitment to a delivery system that assesses need for service, develops service plans, integrates and coordinates health, housing, and social service components, provides case management for clients and serves as a liaison between doctors, hospitals, nursing homes and community programs.

While the act offers us a chance to establish the Federal commitment, it must be accompanied by funds to operate the system. Funding for 3(b) services has not increased in several years and further mandates without funding will only weaken the act.

Since fiscal 1981, Federal funds for 3(b) services have dropped 4 percent nationally. In that period Massachusetts has increased its funding for home care services from $46 million to over $85 million, an 85-percent increase in State funds.

Funds for community care can best be found in our health programs, medicare and medicaid.

Since 1981, Federal expenditures from medicaid have increased $4.1 billion or 24 percent. If this trend continues over the next 4 years, diverting 10 percent of the future growth in medicaid funds for community care programs could mean $410 million to keep frail seniors at home. A similar impact might be made in medicare by expanding funding for channeling-type programs. The ineffectiveness of our long-term care efforts to date have followed the weaknesses in the funding streams. We can begin to prepare the system to deliver community care with funds from the Older Americans Act but an effective system must tap funds from other programs to create the balance, the integration, and the coordination needed between institutional and community long-term care systems.

Thank you very much.

[The prepared statement of Dr. Rowland and responses to questions submitted by Senator Grassley follow:]

TESTIMONY OF

RICHARD E. ROWLAND, Ph.D.

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO PRESENT MY VIEWS ON LONG TERM CARE on THE OLDER AMERICANS' ACT. YOUR INTEREST IN LONG TERM CARE IS MOST TIMELY IN VIEW OF CHANGING DEMOGRAPHICS, SKY-ROCKETING ANNUAL INCREASES IN THE COST OF HEALTH CARE AND THE LOOMING CRISIS IN MEDICARE. WE MUST SET NEW DIRECTIONS SOON TO FORESTALL THE CATASTROPHY THAT MOST CERTAINLY AWAITS US. WE MUST CREATE A FEDERAL COMMITMENT TO COMMUNITY CARE AND THE METHODS OF DELIVERING AND FINANCING SERVICES TO HALT OUR CONTINUING RELIANCE ON INSTITUTIONAL SERVICES.

SERVICES TO SENIORS ARE A MAJOR PRIORITY OF STATE GOVERNMENT IN MASSACHUSETTS AND HAVE BEEN FOR TEN YEARS. THERE ARE OVER 726,000 PEOPLE OVER 65 IN MASSACHUSETTS, 12.7% OF OUR POPULATION. AN ESTIMATED 6.5% OF THEM LIVE IN NURSING HOMES, REST HOMES, OR CHRONIC CARE FACILITIES. ANOTHER 43,000 SENIORS RECEIVE SOCIAL SERVICES THROUGH OUR STATE FUNDED HOME CARE PROGRAM.

GOVERNOR DUKAKIS AND OUR STATE LEGISLATURE HAVE COMMITTED $87 MILLION FOR SOCIAL AND NUTRITION SERVICES THIS YEAR AND $94 MILLION in state money HAS BEEN REQUESTED FOR NEXT YEAR. BY CONTRAST, MASSACHUSETTS RECEIVES JUST UNDER $17 MILLION FROM TITLE III OF THE OLDER AMERICANS' ACT FOR SOCIAL SERVICES AND NUTRITION PROGRAMS. THE FEDERAL COMMITMENT TO COMMUNITY-BASED CARE IS LAGGING.

IN ADDITION TO THE STATE HOME CARE PROGRAM, MASSACHUSETTS SPENDS $22 MILLION IN MEDICAID FUNDS FOR COMMUNITY-BASED SERVICES SUCH AS HOME HEALTH, ADULT DAY HEALTH, AND FOSTER CARE. WE SPEND ANOTHER $2 MILLION TO SUPPORT 200 SENIORS IN CONGREGATE HOUSING WITH A GOAL OF FUNDING UP TO 500 ADDITIONAL CONGREGATE HOUSING UNITS OVER THE NEXT TWO YEARS.

WHILE OUR COMMITMENT TO COMMUNITY SERVICES IS STRONG, MASSACHUSETTS STILL SPENDS CLOSE TO $500 MILLION FOR NURSING HOME CARE, A LOPSIDED TILT TOWARD INSTITUTIONAL CARE IN A STATE THAT IS COMMITTED TO COMMUNITY OPTIONS FOR THOSE WHO PREFER THEM.

STATE FUNDED PROGRAMS ARE ADMINISTERED THROUGH 27 HOME CARE CORPORATIONS, WHICH ARE NON-PROFIT AGENCIES WHO CONTRACT WITH THE STATE TO SERVE FRAIL ELDERS. THE STATE ALSO HAS ESTABLISHED 23 AREA AGENCIES ON AGING. IN 20 AREAS THE HOME CARE CORPORATION HAS BEEN DESIGNATED AS THE AREA AGENCY. THREE AREA AGENCIES OPERATE INDEPENDENTLY OF THE HOME CARE SYSTEM AND ONE OF THESE IS A LOCAL GOVERNMENTAL UNIT.

THE FOCUS OF THIS HEARING IS THE ORGANIZATION OF LONG TERM CARE SERVICES UNDER THE OLDER AMERICANS' ACT AND THE UTILITY OF A SINGLE AGENCY TO ADMINISTER COMMUNITY SERVICES. WE FAVOR THE CONCEPT OF A SINGLE ENTRY POINT FOR LONG TERM CARE SERVICES. SINCE OUR HOME CARE SYSTEM WAS ESTABLISHED AS A SOCIAL SERVICE SYSTEM TEN YEARS AGO, WE HAVE LEARNED A GREAT DEAL. TEN YEARS AGO THE ADDITION OF SOCIAL SERVICES FILLED A MAJOR GAP. TODAY, THE GAP IS LARGELY FILLED, BUT WE LACK THE INTEGRATION BETWEEN HEALTH AND

SOCIAL SERVICES THAT AN EFFICIENT SYSTEM MUST HAVE, AND WE ARE NOW MOVING TO INTEGRATE THESE SERVICES. THE OLDER AMERICANS' ACT COULD MAKE A SUBSTANTIAL CONTRIBUTION TO THE SINGLE COMMUNITY AGENCY CONCEPT BY STRESSING THE NEED FOR AN INTEGRATED SYSTEM.

THE SINGLE AGENCY MODEL IN MASSACHUSETTS HAS HELPED CENTRALIZE ASSESSMENT, CARE PLANNING, AUTHORIZATION OF SERVICES AND CASE MANAGEMENT FUNCTIONS. OUR HOME CARE AGENCIES FULFILL THESE FUNCTIONS AND THEY PURCHASE SERVICES FROM LOCAL PROVIDERS. SIXTY-SEVEN (67%) PERCENT OF THE SERVICES PURCHASED ARE HOMEMAKER SERVICES. CASE MANAGEMENT, STATE FUNDED HOME DELIVERED MEALS, CHORE SERVICES, AND TRANSPORTATION ACCOUNT FOR THE REST OF OUR SERVICE EXPENDITURES.

OUR SYSTEM IS CHANGING TO TARGET SERVICES TO THOSE WHO ARE MOST AT RISK OF ADMISSION TO A NURSING HOME. THE CHANNELING DEMONSTRATION PROGRAM HAS BEEN EXTREMELY HELPFUL TO US AS WE IMPROVE OUR SYSTEM.

THE LYNN CHANNELING PROGRAM SERVES 300 FRAIL SENIORS WHO ARE ELIGIBLE FOR NURSING HOME CARE BUT CHOSE INSTEAD TO REMAIN AT HOME WITH SUPPORT FROM SOCIAL SERVICE PROGRAMS. THIS PROGRAM HAS DEMONSTRATED THE IMPORTANCE OF SOCIAL SERVICES FOR KEEPING PEOPLE AT HOME AND THE BENEFITS OF INTEGRATING THE DELIVERY OF HEALTH AND SOCIAL SERVICES THROUGH A SINGLE AGENCY.

SOCIAL SERVICES COMPRISED 80 PERCENT OF THE SERVICES USED BY CHANNELING CLIENTS WITH HOMEMAKER - PERSONAL CARE SERVICES THE

SINGLE MOST UTILIZED SERVICE. HEALTH SERVICES, HOME HEALTH AIDE, DAY HEALTH, FOSTER CARE, SKILLED NURSING, FOSTER CARE AND MEDICAL SUPPLIES, COMPRISED 20 PERCENT OF SERVICE EXPENDITURES IN THE FIRST YEAR. THE CHANNELING PROGRAM HAS DEMONSTRATED THE IMPORTANCE OF OFFERING SERVICES ON NIGHTS AND WEEKENDS. OVER 50 PERCENT OF CHANNELING CLIENTS RECEIVED SERVICES ON "OFF" HOURS AND MOST OF THESE CLIENTS RECEIVED 11 - 30 PERCENT OF THEIR CARE ON NIGHTS AND WEEKENDS.

WHILE SOCIAL SERVICES WERE THE MOST UTILIZED SERVICES, THE CHANNELING MODEL MAKES USE OF HEALTH CARE EXPERTISE. CASE MANAGERS ARE SUPERVISED BY A REGISTERED NURSE AND A MASTER'S LEVEL/ SOCIAL WORKER. THE NURSING EXPERTISE IS IMPORTANT TO SUCCESSFULLY ADDRESS THE HEALTH NEEDS OF FRAIL CLIENTS.

AS A RESULT OF OUR CHANNELING EXPERIENCE, WE HAVE ADDED PERSONAL CARE AS A COMPONENT OF OUR HOMEMAKER SERVICE, AND OUR HOME CARE CORPORATIONS ARE HIRING NURSES TO PROVIDE CONSULTATION AND SUPERVISION TO CASE MANAGERS. THE SINGLE AGENCY MODEL HAS BEEN CRUCIAL TO THE CASE PLANNING AND SERVICE AUTHORIZATION OF A COMPLICATED SERVICE PACKAGE TO VERY FRAIL CLIENTS. SERVICE GAPS, POOR COORDINATION AND MISSED ASSIGNMENTS MAY MEAN ADMISSION TO AN INSTITUTION FOR SOME CLIENTS.

A MODERATE CENTRALIZATION MODEL WHERE A SINGLE AGENCY DOES ASSESSMENT, AUTHORIZATION, CASE MANAGEMENT AND DIRECT SERVICES ARE PURCHASED WORKS WELL IN MASSACHUSETTS.

SELECTING THE DESIGNATED AGENCY, HOWEVER, MUST REFLECT EXPERIENCES AND CONDITIONS THAT VARY STATE BY STATE. IN MASSACHUSETTS A HEALTH AGENCY TIED TO MEDICARE WOULD NOT BE AN APPROPRIATE CHOICE. WHILE ACCESS TO MEDICAL SERVICES IS IMPORTANT, EXPERIENCE WITH CASE MANAGEMENT AND SOCIAL SERVICES IS VITAL. A LOCAL GENERAL SOCIAL SERVICE AGENCY MAY HAVE A MANDATE THAT IS TOO BROAD TO DEVELOP THE SUPPORT AND SERVICE SYSTEMS NEEDED BY VERY FRAIL ELDERS. WHILE AREA AGENCIES ON AGING COULD SERVE AS A DESIGNATED AGENCY, THERE ARE SOME ISSUES THAT NEED DISCUSSION. WE NEED TO EXAMINE THE IMPLICATIONS OF LOCATING ADVOCACY AND DELIVERY, OR DIRECT SERVICE DELIVERY AND CASE MANAGEMENT IN ONE AGENCY. WE ALSO MUST CONSIDER THE PRESENT STRUCTURE OF DESIGNATIONS IN MASSACHUSETTS. A MANDATE TO DESIGNATE THE AAAs WOULD FORCE SUBSTANTIAL CHANGES IN OUR SYSTEM THAT MAY NOT BE NECESSARY TO ESTABLISH AN EFFECTIVE COMMUNITY-BASED SYSTEM.

THE OLDER AMERICANS ACT SHOULD SPECIFY THE FUNCTIONS THAT MIGHT BE LOCATED IN A DESIGNATED LONG TERM CARE AGENCY OR THE CRITERIA TO BE USED IN DESIGNATING AN AGENCY. BUT STATES SHOULD HAVE THE FLEXIBILITY TO MAKE DESIGNATIONS THAT REFLECT VARIATIONS IN THE DELIVERY SYSTEMS AMONG THE STATES.

THERE ARE SEVERAL OTHER ISSUES THAT ARE CRUCIAL TO THE OPERATION OF A COMMUNITY-BASED SYSTEM OF CARE. FIRST, THERE CAN BE NO EFFECTIVE FEDERAL MANDATE WITHOUT AN ADEQUATE FINANCIAL COMMITMENT TO CARRY IT OUT. A MANDATE TO DESIGNATE LONG TERM CARE AGENCIES WILL OFFER FALSE HOPES TO THOSE WHO ARE LOOKING EAGERLY

FOR AN ALTERNATIVE TO A NURSING HOME. THE STRUCTURE WITHOUT THE FUNDING WILL LEAVE A BEAUTIFUL, BUT EMPTY, HOUSE AND IT WILL UNDERMINE PUBLIC SUPPORT FOR THE PROGRAM.

THE OLDER AMERICANS' ACT IS A GOOD VEHICLE TO SHAPE THE DIRECTION OF LONG TERM CARE. IT EMBODIES THE COMMITMENT TO COMMUNITY CARE THAT IS ABSENT FROM MEDICAID AND MEDICARE EXCEPT IN THEIR DEMONSTRATION AND WAIVER PROJECTS. MEDICARE IS HEADING IN THE WRONG DIRECTION. HOSPITAL COST CONTAINMENT PROGRAMS ARE BRINGING ELDERLY PEOPLE BACK TO THE COMMUNITY SOONER AND SICKER. YET, MEDICARE ONLY REIMBURSES HOME HEALTH CARE ON AN INTERMITTENT BASIS AND IT FAILS TO PAY FOR MANY SERVICES. TODAY'S PATIENTS NEED DAILY CARE AND A PROGRAM TO PAY FOR IT. THE PROPOSALS TO CUT MEDICARE DEFICITS WILL MEAN MORE COST SHIFTING TO SENIORS WHO CAN'T AFFORD IT AND THE FAILURE TO DEVELOP THE COMMUNITY SERVICES THAT ARE NEEDED. IT MAKES LITTLE SENSE TO EXPAND THE LONG TERM CARE SYSTEM UNDER THE OLDER AMERICANS' ACT IF IT IS UNDERMINED BY CUTS IN MEDICARE.

INSTEAD WE MUST BUILD UPON THE EARLY SUCCESS OF HHS's CHANNELING DEMONSTRATION PROGRAM. CHANNELING HAS SUCCESSFULLY KEPT PEOPLE AT HOME WHO WERE READY TO BE PLACED IN A NURSING HOME. IT WORKS FOR TWO REASONS: HEALTH MONEY WAS USED FOR SOCIAL SUPPORT SERVICES, AND FUNDS WERE "POOLED" AND FREED FROM ELIGIBILITY CRITERIA AND BENEFIT RESTRICTIONS. FRAIL PEOPLE NEED A SYSTEM THAT RESPONDS QUICKLY AND OFFERS A RANGE OF SERVICES. THEY CAN'T STAY IN THE COMMUNITY UNTIL SERVICE PACKAGES ARE PIECED

AND GLUED TOGETHER. CHANNELING ASSESSED A PERSON'S SOCIAL AND HEALTH NEEDS AND AUTHORIZED THE NECESSARY SERVICES REGARDLESS OF THE CLIENT'S FUNDING SOURCE. AN OVERALL CAP ON EXPENDITURE RATES HAS KEPT THE PROGRAM COST EFFECTIVE.

A SECOND KEY ISSUE IS THE LINKAGES BETWEEN COMMUNITY AND INSTITUTIONAL SERVICES. TO CARE FOR PEOPLE IN AN APPROPRIATE SETTING, BOTH INSTITUTIONAL AND COMMUNITY PROVIDERS MUST COORDINATE ASSESSMENTS, REFERRALS AND SERVICES. THE ABSENCE OF A CONTROLLING MECHANISM TO SCREEN INSTITUTIONAL PLACEMENTS LEAVES A MAJOR WEAKNESS IN THE TWO SYSTEMS OF CARE. EACH HAS OPERATED INDEPENDENT OF THE OTHER.

SUPPORT FOR EXPANDING COMMUNITY CARE MAY ONLY EMERGE IF IT HOLDS PROMISE OF LIMITING THE GROWTH IN INSTITUTIONAL SERVICES. THE TWO SYSTEMS CANNOT OPERATE ON PARALLEL TRACKS. IF THE SUPPLY OF ALTERNATIVE SERVICES EXPANDS IN AN AREA, THERE MUST BE A REDUCTION IN THE PLANNED GROWTH OF INSTITUTIONAL CARE. NURSING HOME PRESCREENING PROGRAMS HAVE TRIED TO FILL THIS GATEKEEPER ROLE. THEY HAVE MET WITH MIXED RESULTS BUT THE CONCEPT REMAINS VALID. WE NEED A PROCESS THAT OFFERS COMMUNITY CARE TO PEOPLE FOR WHOM IT'S APPROPRIATE AND WE MUST BALANCE THE GROWTH OF COMMUNITY AND INSTITUTIONAL SERVICES. IN THE END THEY ARE COMPETING FOR THE SAME MONEY. IF MEDICARE AND MEDICAID COSTS FOR INSTITUTIONAL CARE CONTINUE TO RISE, THERE WILL NOT BE ENOUGH MONEY TO BUILD A FEDERAL COMMITMENT TO COMMUNITY CARE. THIS INSTITUTIONAL BIAS OF MEDICAID AND MEDICARE MUST BE HALTED IF COMMUNITY CARE IS TO PLAY

A ROLE IN DEVELOPING HUMANE AND MORE EFFECTIVE CHRONIC CARE SERVICES FOR ELDERS IN THEIR HOMES.

THE OLDER AMERICANS' ACT OFFERS AN OPPORTUNITY TO MAKE SIGNIFICANT ADVANCES IN A NATIONWIDE SYSTEM FOR DELIVERING LONG TERM CARE SERVICES. IT CAN SERVE AS A MECHANISM FOR CREATING THE FEDERAL COMMITMENT TO A DELIVERY SYSTEM THAT ASSESSES THE NEED FOR SERVICE, DEVELOPS SERVICE PLANS, INTEGRATES AND COORDINATES HEALTH, HOUSING AND SOCIAL SERVICE COMPONENTS, PROVIDES CASE MANAGEMENT FOR CLIENTS AND SERVES AS A LIAISON BETWEEN DOCTORS, HOSPITALS, NURSING HOMES AND COMMUNITY PROGRAMS. THE SINGLE AGENCY MODEL MEETS THIS TEST VERY WELL IN MASSACHUSETTS .

WHILE THE ACT OFFERS US A CHANCE TO ESTABLISH THE FEDERAL COMMITMENT, IT MUST BE ACCOMPANIED BY A COMMITMENT TO FUND THE SYSTEM. FUNDING FOR TITLE IIIB SERVICES HAS NOT INCREASED IN SEVERAL YEARS AND FURTHER MANDATES WITHOUT INCREASED FUNDING WILL ONLY WEAKEN THE ACT.

SINCE FISCAL 1981, FEDERAL FUNDS FOR TITLE IIIB SERVICES HAVE DROPPED OVER 4 PERCENT FROM $252 MILLION TO $241 MILLION. IN THAT PERIOD, MASSACHUSETTS HAS INCREASED ITS FUNDING FOR HOME CARE SERVICES FROM $46 MILLION TO $85.4 MILLION, AN 85 PERCENT INCREASE.

WHERE CAN WE FIND FEDERAL MONEY TO FULFILL THE MANDATE? FUNDS FOR COMMUNITY CARE CAN BEST BE FOUND IN OUR HEALTH PROGRAMS, MEDICARE AND MEDICAID.

SINCE 1981, FEDERAL EXPENDITURES FOR MEDICAID HAVE INCREASED $4.1 BILLION OR 24 PERCENT. IF THIS TREND CONTINUES OVER THE NEXT FOUR YEARS, DIVERTING TEN (10%) PERCENT OF THE FUTURE GROWTH IN MEDICAID FUNDS FOR COMMUNITY LONG TERM CARE PROGRAMS COULD MEAN $410 MILLION TO KEEP FRAIL SENIORS AT HOME. A SIMILAR IMPACT MIGHT BE MADE IN MEDICARE BY EXPANDING THE MEDICARE FUNDING FOR CHANNELING TYPE PROGRAMS.

WE CANNOT REALISTICALLY EXPECT A TOTALLY NEW SOURCE OF FUNDING FOR LONG TERM CARE THAT FAILS TO COORDINATE SERVICES AND FUNDING WITH THESE LARGER PROGRAMS. THE WEAKNESS OF OUR EFFORTS TO DATE HAVE FOLLOWED THE WEAKNESS IN THE FUNDING STREAMS. WE CAN READY THE SYSTEM TO DELIVER COMMUNITY CARE WITH FUNDS FROM THE OLDER AMERICANS' ACT, AND WE MAY SEE ENOUGH TITLE III FUNDS TO OPERATE AT A MINIMAL LEVEL, BUT AN EFFECTIVE SYSTEM MUST TAP FUNDS FROM OTHER PROGRAMS TO CREATE THE BALANCE, THE INTEGRATION AND COORDINATION NEEDED BETWEEN THE INSTITUTIONAL AND COMMUNITY SYSTEMS.

THANK YOU.

RESPONSES OF RICHARD H. ROWLAND, Ph.D., SECRETARY
DEPARTMENT OF ELDER AFFAIRS
COMMONWEALTH OF MASSACHUSETTS

1. You are interested in the coordination of the Older Americans Act programs with such other programs as Title XX and Title XIX.

Hasn't it become much easier with the block granting of Title XX and the Section 2176 Waivers to do this? And what else is needed?

RESPONSE:

While long term care services must be coordinated with other programs, the most effective linkages lie with our health programs - Medicaid and Medicare. Creation of the Social Services Block Grant has not affected the delivery of community care in Massachusetts. The funds available from the block grant are simply not adequate to support the broad range of services provided by our state. Too many needs compete for limited funds to support our Community Care program.

While Section 2176 has broken new ground for improving long term care, it contains restraints that will limit its reach. The Section 2176 regulations focus on aggregate per capita costs with and without the waiver which dilutes the comparison of individual client costs. The waiver regulations anticipates that aggregate spending will be less with the waiver authority but the waivers have very limited ability to curtail aggregate spending. A few states have used the waivers to close facilities, primarily for the mentally retarded, in favor of community care. For the elderly, this strategy requires a much more difficult course -- closing nursing home beds that are available to both Medicaid and private paying people to ensure that Medicaid costs will not increase. While this is a desirable consequence of the expansion of community care, it cannot happen as quickly as the 2176 formula requires.

In short, the waiver authority is a welcome step toward diverting health funds to services that reduce the use of institutional care, but is is only a first step.

2. Dr. Rowland, I take it from your statement that Massachusetts area agencies do correspond to the single local agency model you described in your presentation?

Can you tell us what changes were required at the state level to accomplish this?

RESPONSE:

The Massachusetts single agency model was created by state legislation in 1973. The law established the authority of the Executive Office of Elder Affairs to contract with local Home Care Corporations to provide case management services to people over 60 who need a range of social services. A copy of our statute is attached

3. It appears from your statement that you already have a centralized model in which area agencies are providing assessment and case management, authorizing and purchasing services.

Could you expand a bit on your point that designation of are agencies as the single agency would force substantial changes in your system? It's not immediately obvious why this would be so.

RESPONSE:

The Massachusetts system has twenty-seven agencies that are presently designated as Home Care Corporations. These agencies receive state funds for case management, homemaker-personal care, meals, chore and transportation services. In twenty areas, the Home Care Corporations also serve as the designated Area Agency on Aging. Yet six Home Care agencies do not serve as the AAA. Those areas are served by three separately designated Area Agencies. To mandate designation of the AAAs to provide assessment, case management, authorization and purchase of services would force redesignation of the system in seven of our twenty-seven home care areas, or three of our 23 AAA areas. We feel the functions performed by the designated community care agency should be the primary federal concern rather than the specific entity designated to do so.

4. Would it be correct to infer from your statement that the highest priority at the moment should be placed on diverting and integrating funds from the health programs and applying them to development of community-based long-term care?

RESPONSE:

Yes, if community care systems are expected to curtail the growth in the use of institutional care, it seems reasonable to divert funds from those programs that now pay for institutional care to support the growth of community systems.

5. In this connection, you mention that the channeling demon-has been helpful to you as you sought to improve your system. I take it that you think enough is now known of the channeling demonstration to proceed with definite development of long-term care systems, rather than remaining tentative and experimental until these demonstrations finish and until we know more about how the Section 2176 waiver programs are working out?

RESPONSE:

The experience of the Channeling program in our state has confirmed the trends we have experienced in our state funded home care program. Social services and a strong case management system are effective in allowing frail seniors to live in the community with their friends and relatives. Channeling helped us fine tune our state program. We have added personal care and adult social day care to our service package and we recognize the need to offer services on nights and weekends if frail elders are to be offered a real alternative to institutional care.

The 2176 waiver is not a true test of the effectiveness of the community care system. It has instead been constrained to measure aggregate Medicaid spending in an artificial test that is not related to the ability of community care to serve people in the community. The waiver authority has been a positive advance in Medicaid but the results will not determine that validity of the single agency model or the impact of community care. The 2176 waiver may yield valuable data on the impact of community care on Medicaid but this context is too narrow. Community versus institutional care extends beyond Medicaid. Channeling, with its "pooling" of Medicare, Medicaid, and state funds in our site, is a better test of community care.

6. You indicate that the Massachusetts system is changing to target services to those most at risk of nursing home admission. What types of clients have you been serving in the past? And how are you proposing to change the targeting system?

RESPONSE:

For the last four (4) years, the Massachusetts Home Care Program has been categorizing clients based on level of need for home care services. The program currently uses six priority categories, with categories 1, 2, and 3 containing clients with severe needs for home care services and clients who would be institutionalized without home care services. Category 4 clients are those with moderate needs for home care services, and categories 5, and 6 are clients with minimal needs for these services. At the beginning of this

RESPONSE: QUESTION 6 (CONT'D)

year, only 11% of our clients statewide fell into categories 1 - 3. Another 20% were rated category 4; however, 69% of the home care clients fell into the minimal need categories of 5 and 6.

We have begun to change the targeting system in a number of ways. First, following a mandate from the State Legislature, we have stressed the need to target services to frailer clients and have set caseload mix goals for those home care agencies with over 60% of their clients in categories 5 and 6. These goals call for up to a 10% decrease this year in clients with only minimal needs for home care services. These goals are to be met through attrition and intake management. Home Care agencies have also been instructed to improve outreach techniques and to coordinate more closely with nursing homes and hospitals in order to reach frailer clients. In addition, the current client needs assessment instrument is being revised to improve the determination of functional level and need for service. The new instrument will reflect not only the client's need for home care services, but also overall level of frailty and will form the basis for new priority categories.

7. You indicate that community-based systems will emerge if they reduce institutional growth. Has this been the case in Massachusetts? Because of demographic factors, won't there be an ever greater need for nursing homes, despite a potential growth in home care type services?

RESPONSE:

Several factors have influenced the supply of nursing home beds in Massachusetts. Some of these are the reimbursement methodology, the availability of financing, the determination of need methodology and practice, and industry shift from single level to multi-level nursing home facilities and the growth of alternative methods of care. Our Home Care program is one factor. It has grown substantially over the past eight years.

Since 1978, the supply of intermediate care facilities has fallen by 8%. Yet the bed need guidelines used by the Determination of Need program during that period called for a 14% decline. Our supply of nursing home beds has reflected the growth of home care.

Community care can influence the growth in the supply of nursing home beds. Demographic trends are another important variable. In Massachusetts we have a shortage of skilled nursing beds and a modest surplus of intermediate care beds. An expansion of community care will not eliminate the need for additional beds but it can reduce the size of the growth. The actual impact of community care on nursing home bed supply depends upon the process for granting approval for additional nursing home beds in each state. Increased supply of community care can check the growth rate of institutional beds with a structured procedure for determining bed needs. In the absence of a determination of need process, both systems will develop along parallel tracks.

Senator **Grassley**. Ms. Ferguson.

Ms. **Ferguson**. Mr. Chairman, thank you.

I am Wilda Ferguson, Commissioner of the Virginia Department for the Aging and a member of the board of directors of the National Association of State Units on Aging.

I am pleased to present the viewpoint of the association on the critical issue of long-term care.

NASUA is a national public interest organization which provides information, technical assistance, and professional development support to its members, the Nation's 57 State units on aging. The association provides an organized channel for State leadership in aging to exchange information and mutual experiences, and to join together for appropriate action on behalf of the elderly. I am pleased to present the viewpoint of the association on the critical issue of long-term care.

From its beginning, the Older Americans Act has affirmed the preservation of independence and dignity as the ultimate goal of the network's efforts on behalf of the older people. Understanding the implications of that goal for frail older people in relationship to long-term care has been a challenging, but constructive process.

In attempting to translate this understanding into an operational system, State units on aging have achieved a substantial consensus on the key components that ought to be developed. These include:

One, an easily known and accessible place for older persons to seek assistance;

Two, an assessment mechanism that comprehensively measures the individual needs, resources, and preferences of older persons seeking help;

Three, a case or service planning system that specifies the formal and informal assistance required to meet client needs and preferences;

Four, a case management component that identifies and oversees the provision of assistance in accord with the case plan;

Five, a financing system that flexibly responds to individual client service needs and which does not bias the quality or quantity of care based on ability to pay;

Six, procedures to ensure the targeting of limited public resources to those most in need and least able to help themselves; and

Seven, a complete and balanced range of community and institutional services for all clients in need.

In NASUA's judgment, creation and maintenance of this kind of long-term care system ought to be a more explicit objective of the Older Americans Act and thus a more visible responsibility of both State and area agencies on aging.

Taken as a whole, the reauthorized act should clearly expect and enable State and area agency involvement in the following areas:

One, advocacy for long-term care system reform, including where appropriate the expenditure of Older Americans Act resources to promote desired changes in the delivery of services.

Two, advocacy on behalf of individual older people concerning their access to and the quality of long-term care and services.

Three, involvement in State and local long-term care system planning, design and coordination.

Four, involvement in the planning and allocation decisions governing medical assistance, social services block funds, and other resources that determine the level and character of long-term care available to older persons.

Five, and, where appropriate and needed, involvement in the direct provision of assessment and case management for long-term care clients.

In calling for increased statutory recognition of these network responsibilities, NASUA does not envision or recommend a mandated uniformity of roles nor an exclusive concentration on long-term care at the expense of other interests and needs of older persons.

In our view, the distinct hallmark of the Older Americans Act has been its deliberate support of a structural and functional freedom that allows State and area agencies to reflect and use differing local circumstances to advance the broad social and economic interests of older persons.

It is our conclusion that this special character ought to be preserved not only as the central thrust of the act, but also as the basis for involvement in long-term care.

The Assistance Group for Human Resources Development recently conducted a study of community care systems administered by State units on aging and area agencies on aging in four States. One of their overriding conclusions was that there is no ideal system which can be used for replication elsewhere. While each system examined contains many elements which can be adapted for use in other States, each State's strategy must be based upon its unique political, historical, and administrative environment.

State units on aging are involved in a variety of efforts within State government to assist in developing community-based long-term care. State units on aging are working with their counterparts in State government to address such issues as policies for the establishment of case management services; development of consistent client assessment procedures; methods for reconciling diverse client eligibility criteria for various programs; and creation of compatible service definitions, standards, and reporting procedures. We believe that State leadership in these areas is imperative to the development of statewide systems of community care which are responsive to the needs of older persons.

While all State units administer Older Americans Act programs, there is substantial diversity in the scope of other functions. Half of the resources administered by State units are from other sources than the Older Americans Act. Primarily these include specific State appropriations for community care, social services block grant funds, and medicaid personal care services.

A number of State units have made tremendous advances in utilizing a variety of funding sources to develop comprehensive services delivery systems such as the one just described by Dr. Rowland.

We believe that States, area agencies, and service providers should be required to give priority to meeting the needs of minority, low income, limited English speaking, seriously impaired, and isolated older persons. It is imperative that the network focus its attention on serving the frail, particularly those in most danger of losing their independence.

Let me say just one comment about Virginia.

In the Commonwealth, we have moved to coordinate the activities of all those State agencies involved in the provision of long-term care services. Two years ago, the general assembly passed legislation at the request of Gov. Charles S. Robb, to establish a coordinating body on the State level, the Long Term Care Council. This council consists of the commissioners of the department of aging, health, social services, mental health and mental retardation, rehabilitation services, visually handicapped, and the Virginia Center on Aging and is chaired by the secretary on human resources. The charge to the council was to develop a State policy on long-term care which would guide the development of program plans and budgets for all of the agencies involved in long-term care services. Additionally, the department for the aging, which serves as staff to the Council, was given the responsibility for developing a State long-term care plan.

The second and perhaps the most important aspect of the legislation passed by the general assembly was to establish a partnership between State and local government to address the issue of long-term care. Each local jurisdiction or combination has been required to establish a local long-term care coordinating committee. These committees were to include the local counterparts of the agencies represented on the State council, the nursing home preadmission screening teams, and any other agency that the local government chose to involve. Local governments have organized 69 coordinating committees. They include the department of housing and community development, nursing homes, nursing associations, community action agencies, libraries, planning district commissions, associations for handicapped persons, acute care facilities, hospice care facilities and city managers. The responsibility of the local coordinating committees is to coordinate services for those in need of long-term care, plan for the delivery of long-term care services, and work toward the cost effective provision of these services. The local committees also are to provide plans to the State which will indicate the activities in which they are involved and expound on problems they see in the provision of services. As a result of their initial plan, we are already seeing some problems, particularly that there is a critical shortage of housing and in-home services.

Local committee members have expressed support for the structure which has been developed and many have gone beyond the minimum requirements.

In the second year of operation, we have begun to gather data on a sample population to determine the type and quantity of services that are being used by individuals at risk of institutionalization. By the end of this year, we anticipate being able to identify the problems in concrete terms. Obviously, our next step will be to move toward solutions.

I have talked about NASUA's viewpoints on reauthorization of the Older Americans Act related to long-term care. We look forward to sharing our positions on all aspects of the act at future hearings.

Thank you.

[Responses of Ms. Ferguson to questions submitted by Senator Grassley follow:]

RESPONSES OF WILDA M. FERGUSON TO QUESTIONS BY SENATOR GRASSLEY

QUESTION 1.	You are interested in the coordination of the Older Americans Act programs with such other programs as Title XX and Title XIX. Hasn't it become much easier with the block granting of Title XX and the Section 2176 waivers to do this? And what else is needed?

ANSWER:

The nature of the working relationship among states' agencies varies considerable. The flexibility to use funds to meet state needs which has been provided by such mechanisms as the block granting of Title XX and the Section 2176 waivers has been very helpful. Flexibility in federal requirements is the key to continued success in the area of coordination.

QUESTION 2.	Could you tell me whether you have had any contact with the regional long-term care gerontology centers sponsored by the Administration on Aging? And if you have, have these been useful experiences? Are the centers being helpful, and if they are not, what is the problem?

ANSWER:

As all state units on aging are different, so are the long-term care gerontology centers. For some of the centers, there seemed to have been some difficulty in focusing on the task; however, AoA is providing direction to clarify their role. There surely is a need for academia to help the practitioner by defining the state of the art in long-term care.

QUESTION 3.	Many of the aspects of the community care system the National Association of State Units on Aging seems to envisage parallel those outlined in the area agencies' position paper. Can you detail briefly for us the main points of difference between your two positions?

ANSWER:

The position of NASUA and N4A are consistent in their description of the components needed in a long-term care system. The associations disagree on the strategy to achieve the goals. A major difference is the view of the role of the federal government. Where N4A supports federal mandates, NASUA strongly supports the position that states should have some choice in designing a system to meet their needs.

QUESTION 4. What do you think the role of the Older Americans Act network should be in the provision of mental health care for older persons? Should this be a major concern of the network, or should the primary responsibility for this fall to the mental health system?

ANSWER:

The aging network is not in the position to provide mental health care, the specific issue your question addresses. There is a system already in place which is designed to provide such services, the local community service boards. The mental health system should accept the responsibility for providing mental health services to all citizens regardless of age. Likewise, the aging network should provide services, within the boundaries of the Older Americans Act, to persons over the age of 60 including those who are in need of or are receiving mental health care from another service delivery system.

Senator **GRASSLEY**. Thank you all very much. You each bring expertise from a different area that is going to be very helpful to us in this reauthorization.

I have several questions but I will probably only ask two or three as a matter of time saving and maybe submit the rest to you in writing.

I would like to address my first one to Pat. It refers to means testing.

You, and I think some of our other witnesses, are arguing that the act should allow States to implement a fee or cost sharing system for specific programs in title III. I have taken a position that there should not be any means testing under the Older Americans Act.

On the other hand, I respect those people that have differing views.

In our hearing on targeting which we had last fall, Dr. Binstock, who maybe some of you heard of, argued that means testing is administratively cumbersome and politically controversial. Certainly in part because older Americans do not like means testing.

Is the kind of fee schedule that you envisage a means test? Or if it is not, how does it differ?

Ms. **SCHRAMM**. I would not suggest a means test in the traditional sense associated with, for example, food stamps and other welfare kinds of programs. I would suggest something that is perhaps a little more general but takes into account the notion that a lot of people who are certainly in Delaware, a lot of people who are receiving Older Americans Act services can afford to pay something for those services, and at the present time, under the present law, they are simply allowed to encourage a contribution of some kind which frankly does not really help very much. Our feeling is that to the degree that people can afford to make—to pay something for the services, that would allow us to expand the services to serve others who are more in need.

Senator **GRASSLEY**. OK.

Now I would ask all three of you to respond to the fact that Pat argued that States should serve as the primary administrators of long-term care.

Do the other two of you agree with that point?

Ms. **FERGUSON**. It is difficult to say that any one system should be mandated from the Federal level on State units.

I pointed out in my statement we feel very strongly that States should be allowed to organize themselves as they see best. For example, you have already heard of two different mechanisms that seem to be working for two different commonwealths, and it would seem difficult for me to say that there should be a mandate.

Dr. **ROWLAND**. I would like to second that, Mr. Chairman, just that the Older Americans Act respect the differences in the various States and that the States work out what model works best for that particular State. I do not think we are going to find one model that is going to be satisfactory in all 50 States.

Senator **GRASSLEY**. I am not so sure that I meant to imply—let me ask Pat. You did not mean to use the term mandate?

Ms. **SCHRAMM**. No, sir.

Senator **GRASSLEY**. You used the term primary responsibility.

Ms. SCHRAMM. Yes, primary, and also for coordinating and doing the overall planning which relates to the allocation of funds and so on.

Senator GRASSLEY. Does that or further explanation, just in case you misinterpreted my question, does that change the points that you made?

Dr. ROWLAND. Well, I think that the State really has to be the primary resource of oversight within the State. But if we are talking about where we are going to locate the delivery mechanism in the State and whether it is going to be with the AAA agency or a State agency or a regional agency, I think all of those kinds of questions ought to be left up to the State because, as far as I know, all the delivery mechanisms are different, they start historically at different times and are different paths in their development.

Senator GRASSLEY. OK.

Ms. FERGUSON. I agree with that, Senator.

Senator GRASSLEY. OK.

Now, for Dr. Rowland and Ms. Ferguson.

Could you both tell me whether you have had any contact with regional long-term care gerontological centers sponsored by the Administration on Aging, and if you have, have these been useful experiences? Are the centers being helpful, and if they are not, what is the problem?

Ms. FERGUSON. Like there are 57 different units on aging and they are all different, all of the gerontology centers are also different. I can speak from experience in region three and say that they have not been personally that helpful to me.

One of the advantages, I think, of the concept is keeping universities and the medical profession involved in the issue of long-term care and, if you will, broadening their education as we broaden our own.

One of the disadvantages that I have seen in the manner in which these particular centers have operated is a lack of focus, and it is my understanding that the Administration on Aging has begun moving to help focus their own long-term care issues in what I hope will be the state of the art in long-term care. That will be very, very helpful to us.

Dr. ROWLAND. I would essentially agree with that analysis, Mr. Chairman.

If you locate a center in a university, the needs of the university often become paramount. If you are really interested in developing long-term care consultation services to the States, there is going to have to be some other type of mechanism developed that ensures that will happen. I know that there have been efforts in New England to try to satisfy both the needs of the university and the needs of the State and the Federal regional office, and I do not think anyone is particularly satisfied in what has happened.

Senator GRASSLEY. OK.

That is my last question I am going to ask today. I thank you very much for your participation.

I would like to now call our third panel. Mr. Timothy Fagan and Mr. Steve Farnham. Mr. Fagan and Mr. Farnham are both local administrators and both AAA directors. Mr. Fagan comes to us from Baltimore County Department on Aging and represents today the National Association of Counties. As he will tell us, county governments have a considerable stake in these long-term care and health care questions, and we think that we should hear their perspective on these issues.

Mr. Farnham is director of a Maine Area Agency on Aging. I understand he runs a very good aging program and will tell us a little bit about that today. He will also be speaking for the National Association of AAA's, which has developed a considered position on long-term care matters.

Before you proceed, I would like to recognize Senator Hawkins, who last night I saw on television as a new member of the Foreign Relations Committee, and I invite her to have an opening statement, if you wish, and then we will proceed to this testimony.

Senator **Hawkins**. Thank you, Mr. Chairman.

I am pleased to join you today in a subject that is so important to the United States and especially to my State of Florida, and I have a statement that I will enter in the record.

I am looking forward to hearing all the testimony, especially that of Dr. Pfeiffer, who is from my home State and runs a superb gerontology center there.

[The prepared statement of Senator Hawkins follows:]

PREPARED STATEMENT OF SENATOR PAULA HAWKINS

Mr. Chairman, I am pleased to join you today to hear these distinguished witnesses testify regarding possible improvements in the Older Americans Act. I am sure that they know how privileged they are to have you serving as Chairman of this Subcommittee on Aging. You have demonstrated an impressive understanding and empathy with the problems facing our elderly, not just during the past year of your able leadership of this Subcommittee, but also in your work with the Select Committee on Aging and during your tenure in the House of Representatives.

An example of your leadership is the scheduling of this series of hearings on the reauthorization of the Older Americans Act. Although the Older Americans Act has been one of the most effective laws enacted by Congress to provide services that preserve the independence and dignity of our older citizens, it is not perfect. It can and should be improved. The issue that we address today, the development of a comprehensive and coordinated community based health and social service system for the long-term care needs of the elderly, is among the most important and perhaps the most difficult of the issues we will be considering.

I don't know of any issue that has more importance to this nation than the development of a system of long-term care for older Americans. I know it is tremendously important to my State of Florida, which has a high proportion of elderly residents. Perhaps because of our large and growing elderly population, Florida has been in the forefront of developing alternatives to the institutionalization of the elderly.

We will be hearing later today from Dr. Eric Pfeiffer, the first president of the Association of Long-Term Care Gerontology Centers and the current director of the Suncoast Gerontology Centers in Tampa, Florida. I look forward to his testimony and the advice and suggestions of all the witnesses testifying today regarding how the Older Americans Act can be amended to insure the development of a community-based system of long-term care for our frail elderly.

Senator **Grassley**. Thank you, Senator Hawkins.

Would you proceed in the order I introduced you?

STATEMENTS OF TIMOTHY FAGAN, DIRECTOR, BALTIMORE COUNTY DEPARTMENT OF AGING, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES; AND STEVE FARNHAM, DIRECTOR, AROOSTOCK AREA AGENCY ON AGING, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Mr. **Fagan**. Mr. Chairman, Senator Hawkins, my name is Timothy Fagan. I am the director of the Baltimore County Department of Aging, a department that reached 35,000 elderly people in the past 12 months in our county. I am here today on behalf of the National Association of Counties. I presently serve as the vice chairman for aging on NACo's Human Services Steering Committee. I am also a member of the board of the National Association of County Aging Programs, an affiliate of NACo.

We at NACo appreciate the opportunity to comment on the role of the programs authorized under the Older Americans Act in long-term care service delivery. Counties strongly support the programs authorized under the Older Americans Act and recognize their invaluable contributions to the health and well-being of their elderly constituents. NACo sees nothing in the present act that precludes the involvement of the aging network in the delivery of long-term care. However, we do recommend specific areas where the legislation could provide greater support to the long-term care system. County governments are determined to meet the health care needs of their elderly constituents and in many areas of the country are leading the way for major innovations in long-term care service delivery. We look forward to continued relationships with the aging network to enhance these efforts. The counties are committed to their role in responsibility to the long-term care network.

There are no easy answers in a nation where the elderly population has more than doubled in the last two decades and the costs of health care have skyrocketed. Mr. Chairman, your State of Iowa has the highest rate of growth in the population of people between the ages of 75 and 84. Iowa has the second highest rate of growth in the population of those 85 and over. Although alternatives to institutional health care are necessary, and NACo has long supported such a policy, we must face the fact that the growth in the 85 and over population means many more health-impaired dysfunctional older people requiring higher, more complex levels of care and other kinds of support.

Counties who own long-term care facilities recognize that these counties cannot turn solely to community-based care as a panacea to the long-term health care problem. Instead, we must look at a continuum, including home care and highly skilled care, when appropriate. The question of who shall coordinate these services and make the decisions about appropriate levels of care is before us in consideration of the Older Americans Act reauthorization.

This brings me to a major theme that counties would like to emphasize today—that of responsibility and accountability. For these are inextricably linked to deciding where the buck stops for public service delivery. We at the county level know that the buck stops with us.

Nationwide, counties have a major role in addressing the needs of all older Americans. One-third of the approximately 650 area agencies on aging function as units of county government. Where the area agency is not a unit of county government, counties still allocate substantial revenues to fund or supplement social services and health care for the elderly.

Last year, Iowa spent almost $600,000 and counties spent $800,000 to supplement the programs authorized under the Older Americans Act. My county, Baltimore County, funds and supplements aging programs with over $6 million local tax dollars. This figure broken out represents $3 million in my own department and approximately $1,500,000 in debt service to finance senior centers which act as community-based access and service points for the provision of health care, including community maintenance programs such as adult day care, geriatric evaluations, medical diagnostic clinics, casework, nutrition job and legal counseling.

An additional $1.5 million in local tax revenue supplement State and Federal dollars in our department's of health and social services, providing a wide variety of protective services, homemaker services, and medical services all of which are coordinated through the county department of aging.

County governments carry out their multiple responsibilities for long-term care as providers, financers, planners, and purchasers of health care services. As the major general purpose local government that finances and administers a range of services, including medicaid, medicare, SSI, and Older Americans Act programs, counties are at the center of coordinating and providing a continuum of long-term care services. County governments own approximately 1,000 nursing homes and long-term care units in county hospitals. Of the 1,900 public hospitals in the country, nearly 1,000 are county facilities.

In Iowa, counties own 56 hospitals and 69 county care facilities. As providers of last resort, they care for the poorest and most ill individuals, including those who have been unable to find care elsewhere or have exhausted the benefits which allowed them to remain in private long-term care facilities. In fact, a recent NACo survey of all State attorneys general revealed that counties are legally responsible for the medically indigent in most States. In Iowa, free care and treatment must be furnished in a county hospital to any sick or injured person who fulfills residency requirements and who is indigent.

That is also true in the State of Maryland. County boards of supervisors are also mandated to pay mental health treatment for those unable to pay.

These vast county responsibilities; a 12.5 percent increase in health care expenditures nationwide between 1981–82; county expenditures for health care reaching close to $20 billion per year; and an elderly population that will more than double by the end of this decade makes it incumbent upon all of us to find more efficient ways to ensure that the long-term care needs of our Nation's elderly are met.

NACo endorses a comprehensive system of long-term care that ranges from community-based health and social services to acute and long-term institutional care. I might mention that that linkage is very critical. We stress the interdependency of health services with other human resource programs, such as those authorized under the Older Americans Act. County elected officials are accountable to the public in the streets and the neighborhoods of this country for ensuring that these services are adequately financed and are properly carried out. Therefore, authority for determining how these services are administered, coordinated, and provided should best rest with the local governments who are legally and fiscally accountable. It is county government, nearest to the people and responsible for so many services, that can respond best to the long-term care needs of its citizens by naming the most appropriate agency or combination of agencies for creating mechanisms that will embrace the concept of case management and the coordination of care that we have heard so much about here this morning.

The proliferation of special districts and interest groups at the local level has already eroded the capacity of local government to govern in many instances, and has serious implications for taxpayers asking "Who is really accountable for this system?"

This country is experiencing a reevaluation of the Federal, State, and local roles in the provision of health care and social services. Furthermore, the entire health care financing and delivery system is on the brink of major change. It has to change. Counties are in the forefront of developing major long-term health care innovations. We may not have a perfect system as previously mentioned, but we are well on our way to perfecting one using our leverage as employers and purchasers of health care to affect the marketplace and the provision of public health services. Some counties have chosen the Area Agency on Aging to head up such efforts, while others use their long-term care facilities, health departments or social services agencies as case managers and general brokers or administrators, people that crystallize and pull together these resources at the level of client and caretaker. These responsible and creative efforts by local government would only be stifled if Federal legislation, mandated specific entities at the State or local levels to carry out functions in long-term care.

Finally, every community is different. There are over 3,000 counties with varying degrees of size, populations, income, health, and social service needs. The Federal Government or State cannot decide the needs of each community, the mechanisms, the delivery systems that are most appropriate for them, certainly they can provide guidance and a framework in which that can take place.

NACo has some specific recommendations in regard to the act. I will be very brief in this regard. Our recommendations fall into several categories.

The Older Americans Act, it is our conviction that the Older Americans Act could further enhance and encourage long-term care efforts at the county level if we were to introduce the concept and terminology and semantics of case management into the legislation itself.

We want to emphasize the need to continue to encompass outreach, information and referral, nutrition, employment, transportation and community-based services such as adult day care, health and respite care, home health care, and linkages with the institutional infrastructure in our counties, including acute care facilities, skilled nursing, and intermediate care facilities. These are all really a part of the long-term care system in this country. We would further reinforce the second career training continuing education, senior employment opportunities, and housing assistance which continues to help the elderly to higher levels of productivity and independence and, in fact, are many times just the medicine that an older person needs to clear up a lot of supposed long-term care problems.

We also would like the act to more precisely recognize the contributions of families and natural support systems providing certain incentives, financial and otherwise, to leverage private resources to complement the public support systems. I think we will find that your alternative to institutionalization systems are a lot less expensive because of the contribution of families and other community civic, social and religious resources.

NACo also recommends that the Older Americans Act encourage the aging network, in cooperation with local governments, to work toward ensuring the provision of these concepts and services. We recommend that Area Agencies on Aging include descriptions of such efforts in their area plans.

We recommend that the subcommittee in efforts to maximize local flexibility examine the feasibility of allowing Area Agencies, rather than States, to make decisions regarding the transfer of funds between parts B and C of title III, and that the percentage be increased from 20 to 25 percent.

In addition, we recommend that this subcommittee consider legislative changes which would allow Area Agencies to target certain funds under the Older Americans Act for the unreimbursed costs the counties are experiencing for indigent care if deemed appropriate to the provision of long-term care at the local level.

NACo believes that it is incumbent upon local government to ensure that long-term care is provided in both a fiscally realistic and competent manner. We cannot do this without the support of the Federal and State levels of government. Therefore NACo looks forward to working with you, Mr. Chairman, and members of the subcommittee, to develop the most effective long-term care policies for authorization under the Older Americans Act.

I will be happy to answer any questions that you may have.

[Responses of Mr. Fagan to questions submitted by Senator Grassley follow:]

BALTIMORE COUNTY
DEPARTMENT OF AGING
AREA AGENCY ON AGING
TOWSON, MARYLAND 21204

J. TIMOTHY FAGAN
DIRECTOR

April 3, 1984

The Honorable Charles Grassley
U.S. Senate
Chairman, Sub-committee on Aging
Committee on Labor and Human Resources
Washington, D. C. 20510

Dear Senator Grassley:

The following is in response to the questions raised as a result of my testimony before the Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources, as requested in your letter of February 7, 1984.

1. I did not mean to infer that the state should be by-passed and/or placed in a secondary position to local governments in organizing and administering long-term care services. Counties and/or area agencies are creatures of state government established with enabling authority to carry out various public services related to the health, safety and well being of its residents. The probability of success is further enhanced when county governments are challenged to choose the agency and/or agencies and/or mechanisms appropriate to best administer long-term care services. Certainly whatever local tool is chosen should be subject to guidelines and/or regulations established at the state level. In cases where local counties are unable to establish such an administrative capacity, states naturally would have to take on a direct administrative responsibility for long-term care services. However, many counties in this country are the most appropriate place to deliver long-term care services, have the capacity to do so and are critical to the successful outcomes that elected officials at the federal level seek. The important thing to note is that counties need to be identified as partners in the delivery of long-term care services.

2. Not to underplay the extreme financial pressures counties are confronting with their limited tax revenue sources, counties will continue to supplement federal and state funds in areas that prove cost effective both politically and economically. Perhaps in no other area is it more important to weld together multiple categorical program funds than in the area of long-term care. This welding together of funding sources into a singular system of access and service delivery for long-term care represents the most significant promise in controling spiraling health care costs. In addition, if health insurance premiums can be reduced by successfully reconfiguring existing long-term care resources, the implications to local economic development activities (attracting new industries and the expansion of existing industries) are also at stake.

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3. Unthoughtful reallocation of existing funds from currently funded services to case management and assessment activities could detract from the ability of AAA's to plan, broker and coordinate services. However, a properly designed case management oriented access and delivery system does plan, broker and coordinate services in a much more responsible and cost-effective way at the client/caretaker levels.

4. In response to this question, I would provide the following local example: Baltimore County's AAA has already commissioned a private/public sector committee to establish standards for accessing, case managing and delivering long-term care services. Existing discretionary funds used in long-term care cases would only be allocated through case management functions that have been certified by the local AAA. It is our opinion that this will not only improve the quality of services and the quality of outcomes, but also insure that unneeded, inappropriate or excessive service allocation would be reduced.

5. Perhaps the most unpublicized issue facing older people involves their mental capacity to solve even simple problems related to the activities of daily living. Although the causes of this condition are many, it is my opinion that depression and anxiety represent the major symptoms. Community mental health centers generally target much more profound and visible symptoms such as drug abuse, family violence, and other behaviorally oriented problems which may lead to more severe societal costs including institutionalization. AAA's generally have not been successful in tapping community mental health resources in forms that could be directed to the age-specific needs of the elderly. Something definately needs to be done to correct this problem, and certainly AAA's need to have both a relationship to the resolution of the problem as well as the provision of the services.

6. I have received perhaps a half a dozen publications of research projects originating in long-term care gerontology centers. That has been the extent of my experience. First I would like to state the need for and the value of gerontological centers, or perhaps better stated, gerontological research projects. It is my opinion that the future value of such gerontological efforts would be better served by a two-tier system -- the first tier consisting of national research efforts that work closely with AOA, and the second tier metropolitan and multi-county level paired with a coalition of AAA's and their county/city counterparts. In addition, research and development projects at the national level would tend to address problems of a more scientific nature and projects at the county level would be more practice oriented involving the local aging network. The present "regional" system is not working to the advantage of the aging network and the elderly themselves.

Sincerely,

J. Timothy Fagan, Director
Department of Aging

JTF/hb

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Febrary 7, 1984

Thank you for taking the time from you busy schedule to testify before the subcommittee on Aging on the Long-Term Care under the OAA. Your testimony contributed to the formation of a very valuable hearing record. Due to time constraints, we were unable to put to you the questions which appear on the attached list. I would appreciate it very much if you would respond to these questions in writing and submit them to my subcomittee for inclusion in the hearing record not later than fifteen days from the date of this letter. Additionally you will receive under separate cover the transcript of your remarks with instructions for editing. I look forward to hearing from you. As soon as the record is printed, I will forward it to you. Again, thank you for your insights. Sincerely, Chuck Grassley, Chairman, Sub-committee on Aging. U.S. Senate, Committe on Labor and Human Resources, D.C., 20510.

1. I think you have taken the position that authority for for how long-term care services are administered, coordinated and provided should rest at the local level. The preceding panel took a different tact. Are we talking about different aspects of administration here or do we have a real difference of opinion? Just how do you see the relationship between what the state should do and what local government or area agencies should do in the way of organizing and adminstering lon-gterm care services?

Do you think that counties given their great financial burden relating to long-=term care and health care will be able to continue supplementing state and federal funds for all these programs including the OAA programs?

With a substantial investment of money or staff effort by area agencies in case management assessment activities detract from the ability of AAA's to plan, broker and coordinate services, particularly in light of the fact that major new resources will probably not be available for the OAA?

In our hearing last July on building long-term care systems, William Weissert pointed out that community care systems raised a whole host of new problems and dangers. He asked whether quality assurance in the community care systems could best be handled by the traditional quality assurance agencies or by the area agencies. Were the AAA's to handle this, would they be required to acquire new skills, staffing and responsibilities? Do you think that they are the logical agencies to do this? If so, how would they do it?

What has been your experience in dealing with the mental health problems of the elderly? Have you had relations with community mental health centers, and if so, how would you characterize the realationship? Do you think that AAA's should have a major responsibility in helping to provide mental health services for older people?

What experience have you had with the long=term care gerontology centers? Would you characterize that experience, please.

Senator **Grassley**. Mr. Farnham.

Mr. **Farnham**. I would like to expresss my thanks, first of all, to Senator Grassley and the other members of the committee for the opportunity to address you on the reauthorization of the Older Americans Act. I am Stephen Farnham, director of the Aroostook Area Agency on Aging, Inc., in northern Maine, and I am here today representing the National Association of Area Agencies on Aging. Recently N4A issued a position statement on long-term care and called for some adjustments in the Older Americans Act to reflect what we view as clarifying the intent of the act.

In the past, this act has mandated that the role of an Area Agency on Aging is to include, as a primary function, the determination of needs of the older population, especially that population group that is at social or economic risk. The mandate also has included the responsibility for the development of a comprehensive and coordinated system of services designed to assure that those needs were met. The act also assured that at the local level older people, those most impacted by the act and related services, retained the responsibility for policy and decisionmaking. The needs determination over past years has grown more challenging. As funding resources became less available, as restrictions on services tightened, allocation of available dollars to meet the older population's needs came under close scrutiny at the local level. Older people on our boards and advisory councils began to question whether past decisions had been based on meeting the "desires" of older people or based on their true needs. Aside from the basic needs one has for survival, there is one striking "need" that most older people feel whether they live in Maine or Iowa. That need is independence—to maintain control over their own personal lives, to be able to live in their own home and retain their personal dignity for as long as possible.

Community based long-term care is complex, involving a wide array of health, social, and personal care services ranging across many professional disciplines. Likewise, older people receive services under a variety of authorizations, with different eligibility requirements and administrative structures, in both public and private sectors. In order to provide older people with an accessible, comprehensive system of community based long-term care, several key components are necessary. These are integration and coordination of community services through resource development and management and client assessment through a case management or, as we more appropriately refer to it in Maine, a care management system.

Long-term care has traditionally been interpreted as those services provided on a long-term basis to chronically ill or impaired persons in institutions. As a result, long-term care was commonly viewed as solely delivered by the medical profession. However, the excessive cost of institutional care and the increased demand for noninstitutional community based services by older people and their families have contributed to a growing awareness of, acceptance of, and demand for community based alternatives. Many view the Network on Aging created by the Older Americans Act as providers of services only to the well elderly rather than planners, developers, advocates for and managers of a negotiable continuum of care for older persons and their families in many communities. The mission of the Network on Aging is, and has been, to maximize the capacity of older persons to live independently.

As the Area Agency on Aging in northern Maine, our agency provides for a system of community-based services designed to keep both older people and younger adults with functional problems in their homes. The core of our system is a care management program utilizing social workers from our agency, registered nurses from our agency and from the medicare approved home health agency, and a professional review group with physicians, mental health professionals, therapists, a pharmacist and representatives of clients or their families. Our model is not unique and exists in many States. Our designation as the lead agency in care management and long-term care system development came about by the mutual consent of care providers and institutions in our region. Providing care management was a new step for our agency, yet other care providers had been employing case management techniques for years. We avoided turf battles and charges of duplicating that which already existed simply by the development of a care management model utilizing both health care professionals and social/community service workers. Because we are not a provider of care, we have no self-interest or vested concern to protect. Because we are client centered, that is we are owned and managed by older people, our care management efforts are advocacy based with a concentration on client/family needs rather than organizational problems.

We have retained all traditional services for the elderly and we have developed specialized service such as maintenance home nursing care and expanded home health aide services, personal care aides services, housekeeping service, 24-hour companion service, night care attendants, adult day care in care providing facilities such as nursing homes, family respite care and more. Our system development was a response to the extreme burden being placed on State and Federal budgets by an expanding institutional care system.

The success of our program lies in the fact that we have directly intervened in the lives of more than 350 people preventing or postponing institutionalization. During a 1-year study period, 68 percent of those served by our care managers were classified as medically in need of skilled nursing care in an institution by Bureau of Medical Service Patient Classifiers. Forty-four percent of these clients were over age 80. Eighty-five to 90 percent of program participants had multiproblems, both physical and/or psychological. We found the average cost to the taxpayer for services to these clients to be $418 per month, including all medicare/medicaid home health benefits, social services including meals, homemakers, transportation, et cetera, compared to a public cost in intermediate care facilities of about $900 monthly.

This success has been blunted in recent months. Although we have always been short of cash for services, we are currently overextended in our ability to provide needed care for a number of reasons. What seems to be predominant is the impact of the medicare diagnostic related group system of payment to hospitals is having. We are finding referrals increasing from hospitals and those that are discharged, in some cases, are in much worse shape than we have seen in the past. Our workers have a sense that the poor who are "fortunate" to have both medicare and medicaid coverage are not being impacted by DRGs. They are being retained in hospital beds and needed care is being provided under medicaid. It is the middle-income elderly and those with assets making them ineligible for medicaid that seem to be discharged early and are being referred to us. Four months ago, we had no waiting list for care, yet we did a survey of our care management systems in Maine last week and found 54 people on waiting lists. Cost reductions in medicare is having a direct impact on community services and we need help.

Government has a role in assuring that community based long-term care systems are developed, and also has an obligation to ensure reasonable access to such systems in a consistent manner. Government leadership is essential for ensuring a fair and efficient allocation of resources. For too long, the Federal emphasis has been on funding institutional long-term care and this has resulted in an undersupply of community based health and social services as well as unnecessary institutionalization. There has been an effort to create needed services with a variety of funding sources including the Older Americans Act, social and community services block grants, income maintenance programs, housing programs, medicare, medicaid, et cetera. Very few of these programs have the broad goal of sustaining the impaired individual in the community, so the resulting array of programs are very difficult to coordinate and integrate at the local level due to the differing eligibility criteria, target populations, and administrative network. Despite the diverse goals of these pieces of legislation, State units and area agencies on aging have been able to shape and direct these resources to develop effective community based long-term care systems in a number of States and communities. N4A believes responsibility for service system management must be at the local level.

Reauthorization of the Older Americans Act offers a good chance to establish a Federal commitment to community based long-term care. It offers a chance of integrating, within Federal policy, the social and health system functions designed to keep people independent and within their own homes for as long as possible. We cannot afford to expand, or even maintain, current service delivery systems which focus on costly institutional care nor can we afford to develop a new structure to administer community based long-term care. We have in place a structure that was created to assure coordinated services at the local level. We have seen a system of community based long-term care with care management as the core evolve in a grass roots fashion in response to the need for improved care and system management. Lacking to date has been adequate funding for these efforts though title III has shown that care management concepts and system building can work. More fund sources must be developed, or skewed from other programs such as medicaid or medicare. Above all, the efforts started must be continued and the Older Americans Act is the appropriate vehicle for a Federal effort to coordinate and integrate community based long-term care.

Thank you.

[The prepared statement of the National Association of Area Agencies on Aging and Mr. Farnham's responses to questions submitted by Senator Grassley follow:]

THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING STATEMENT ON COMMUNITY BASED LONG TERM CARE

I. PURPOSE

This policy statement identifies the role of Area Agencies on Aging in developing comprehensive long term care service systems at both the client and community levels. The essential components of community based long term care systems are defined. This statement also proposes changes necessary in the Older Americans Act (OAA) and other relevant legislation which would enhance the ability of Area Agencies on Aging to serve as managers and brokers for developing community based long term care systems.

II. INTRODUCTION

Long term care is complex, involving a wide array of health, social and personal care services ranging across many professional disciplines. Likewise, older persons receive services under a variety of authorizations, with different eligibility requirements and administrative structures, in both public and private sectors. In order to provide older people with an accessible, comprehensive system of community based long term care, several key components are necessary. These are integration and coordination of community services through resource development and management, and client assessment through a case management system.

Long term care has traditionally been interpreted as those services provided on a long term basis to chronically ill or impaired persons in institutions. As a result, long term care was commonly viewed as being solely delivered by the medical profession. However, the excessive cost of institutional care and the increased demand for non-institutional community based services by older people and their families have contributed to a growing awareness and acceptance of community based alternatives. Even though the concept of community based long term care is now beginning to broaden, health professionals still tend to view the Network on Aging as providers of services to the well elderly rather than planners and developers of systems of community based, in-home, and institutional care services. However, the Network on Aging, via its current structure of State and Area Agencies on Aging, has emerged as the developers and managers of a negotiable continuum of care for older persons and their families in many communities. The mission of the Network on Aging is to maximize the capacity of older persons to live independently.

The rapidly growing population age 60 and over necessitates a community based long term care system responsive to its varying needs. Now, one of every nine persons is over the age of 65; within 50 years one in every six persons will be in that category. In fifty years, the aging population will grow from 23 million to 55 million. The increasing older population will require a range of preventive and supportive health and social services.

Older individuals with functional impairments not requiring institutional care face interrelated problems of eligibility determination, needs assessment, care plan development, services access, and financing. Numerous Area Agencies have now moved to create community based long term care systems addressing the multiple needs of the functionally impaired, as well as continuing to provide preventative services to those less impaired older people. Key to the appropriate utilization of these services is the existence of case management.

N4A believes we cannot afford to maintain current service delivery systems which focus on costly institutional care over viable community alternatives nor can we afford a new structure to administer community based long term care. The 1981 White House Conference on Aging (WHCOA) Committee on Long Term Care endorsed a comprehensive national health plan including long term care and community based health systems, and called for the redirecting of resources to a more responsive and comprehensive approach of service delivery to older people. They also recommended that: 1) new structures not be created; and 2) the Network on Aging develop and manage community based long term care systems.

We must ensure that Congress, the Administration, health and human services professionals, and other policy formulators are aware of and recognize that a network of 57 State Units on Aging and 660 Area Agencies on Aging currently exists across the nation charged with the following mandates:

A. Developing comprehensive and coordinated service delivery systems to serve those elderly persons in greatest social or economic need;

B. Acting as a focal point for advocacy for all elderly persons at the local, state, and national levels in both public and private sectors;

C. Developing a comprehensive plan of action as to how the local community can best address the identified needs of elderly persons, and

D. Coordinating service providers, including for profit and voluntary agencies, in the development of comprehensive service delivery systesm.

Statistics from the National Data Base on Aging delineate the high incidence of involvement by Area Agencies on Aging in community based long term care services in 1981. That involvement appears to be growing due to increased targeting toward the most vulnerable elderly.

HEALTH/SUPPORTIVE SERVICE ACTIVITIES PROVIDED BY AREA AGENCIES ON AGING

Programmatic Area/Compound Service*	Area Agencies Providing	
	Number	Percent
Community Based Care	446	83%
Health - Medical	423	78%
Case Management	289	54%
Institutional Care	229	42%
Health - Mental	172	32%
Adult Day Care	135	25%
Health - Dental	43	8%

*See Appendix A for breakdown of service categories.

III. COMMUNITY BASED LONG TERM CARE AND THE OAA MANDATES

N4A proposes the following definition of community based long term care:

"Community based long term care is a range of preventative and supportive health and social services including case management as the central component. Services, delivered in community, home or institutional settings, are appropriately and cost-effectively provided in the least restrictive environment. Community based long term care systems depend on effective service integration and coordination, appropriate client assessment, maximum use of informal supports, accessible services, and evaluation."

Title III of the Older Americans Act mandates Area Agencies to develop comprehensive and coordinated service delivery systems designed to maintain elderly persons in their homes through specific planning, coordination, program development, and advocacy responsibilities. Components of community based long term care systems parallel the responsibilities of Area Agencies on Aging under the Older Americans Act:

Specific Services Provided for in Title III of the OAA Include:

A. Community Based Services - Including case management, outreach, information and referral, transportation, nutrition, senior center services, employment, legal, adult day care, and respite.

B. In-Home Services - Including visiting nurse services, homemaker, home health aide, visiting and telephone reassurance, home-delivered meals, and chore.

Services Commonly Included In Long Term Care Systems:

A. Access Services - Including assessment and case management for functionally impaired older persons.

B. Community Based Services - Adult day care, day health, and respite.

C. In-Home Services - Including home-delivered meals, hospice services, home health aide, homemaker, and chore.

C. Institutional Services - Including advocacy and long term care ombudsman services.

D. Family Support Services - Services which are provided in the home through family, friends, and volunteers.

E. Institutional Services - Including nursing home services.

F. Outpatient services

Integration and coordination efforts of many Area Agencies resulting in effective and appropriate delivery of these services to older persons warrant wide application. For the functionally impaired client, case management is a resource management tool which supports service integration through client assessment, referral to appropriate services, follow-up, and evaluation of services.

Current problems in service integration include:

A. Fragmentation of services and programs;

B. Unavailability of resources;

C. Duplication of administrative responsibilities;

D. Programs working at cross-purposes; and

E. Service provider inefficiencies.

Case management addresses these problems by:

A. Integrating supportive services to meet diverse client needs;

B. Assisting clients to obtain access to a continuum of services;

C. Identifying the at-risk population;

D. Assuring appropriate provision of services;

E. Facilitating development of a broad array of non-institutional services;

F. Evaluating the quality of service provision;

G. Managing competing resources.

Although Area Agencies on Aging are increasingly involved with case management services, the OAA does not mandate that such services be in place within each planning and service area. Area Agency involvement in case management has evolved in a grass roots fashion in response to the need for improved management of community based service delivery systems.

IV. CURRENT LONG TERM CARE COSTS

Health care costs continue to rise at an accelerated rate well above the current inflationary average, precluding access by many economically and socially deprived functionally impaired elderly persons to basic health care and necessary supportive social services. Ironically, such persons often turn to more expensive, publicly subsidized institutional care.

Medicare and Medicaid, which primarily support hospital and nursing home care, comprise the largest source of funding for health care. This emphasis on funding institutional long term care has led to an undersupply of community based long term care services as well as unnecessary institutionalization. Currently less than ten percent of public funds are devoted to home-based care. While many impaired elderly may need no long term care services, there is evidence that 20 to 40 percent of the nursing home population could be cared for at less intensive levels in non-institutional settings.

Government has a role in assuring that community based long term care systems are developed, and also has an obligation to ensure reasonable access to such systems in a consistent manner. Government leadership is essential for ensuring a fair and efficient allocation of resources.

Legislative changes in the Omnibus Budget Reconciliation Act of 1981 allowing for state waivers in Medicaid and limited waivers in Medicare have stimulated more involvement of Area Agencies on Aging in the provision of community based long term care services. Area Agencies welcome this opportunity to assure the accessibility and provision of appropriate community based long term care services to older persons in their communities.

Other sources of funding for community based services are the Social Services Block Grant, the OAA, and the Community Services Block Grant. Income maintenance is provided mainly through Social Security, i.e., Old Age, Survivors, and Disability Insurance and the Supplemental Security Income programs which are federally administered and often used to pay for domiciliary facilities and board and home care. The Veterans Administration provides nursing home care, domiciliary care, and hospital-based home care for eligible veterans, and is federally administered. Housing programs are operated by the Department of Housing and Urban Development, often under state and local administration. Transportation and the Community Development Block Grant programs are state administered. The state administered food stamp program assists the needy to purchase essential food. In addition, many communities use General Revenue Sharing, state and local public funds, and private sector resources to support long term care services.

Very few of these programs have the broad goal of sustaining the impaired individual in the community, so the resulting array of programs are very difficult to coordinate and integrate at the local level due to differing eligibility criteria, target populations, and administrative networks. Despite the diverse goals of these pieces of legislation, State

Units and Area Agencies on Aging have been able to shape and direct these resources to develop effective community based long term care systems in a number of states and communities. N4A believes responsibility for service system management must be at the local level.

As we prepare for the 1984 Reauthorization of the OAA we must strengthen the specific authority of Area Agencies on Aging in the development of community base long term care systems. The following sections address those changes N4A believes are needed in the OAA and other legislation to strengthen that role.

V. RECOMMENDED LEGISLATIVE CHANGES

A. Older Americans Act (OAA)

N4A proposes the Older Americans Act be expanded in the 1984 Reauthorization to embrace the role of State and Area Agencies on Aging in managing and brokering community based long term care systems. We offer the following recommendations in support of this thrust:

1. Title I of the Act should be rewritten to support the following goal: To sustain older persons in the community and in their homes appropriately through the provision of a comprehensive array of community based long term care services.

   This title of the Act should be updated to reflect the focus and future direction of the Network on Aging in developing community based long term care systems.

2. Resource Management should be defined as the directing, redirecting, and integration of current and potential resources through more effective service management, targeting, client tracking, and unit costing to serve older persons with greatest demonstrated need in a way most beneficial to the client.

3. Resource Development should be defined as those activities generating additional resources, both public and private, which establish a comprehensive array of community based long term care services responsive to local needs and resources.

4. Title III of the Act should clearly establish that State Units and Area Agencies on Aging must coordinate and integrate with all programs and funding sources affecting older persons to develop community based long term care systems. The Act should specifically list the following program areas: Social Security Administration, Supplemental Security Income, Title XVIII, Title XIX, Social Services Block Grant, ACTION Programs, Community Services Block Grant, Housing and Urban Development - Section 202, Food Stamps, Department of Transportation - Urban Mass Transit Authority, and Veterans Administration. Further, the Act should mandate that State and Area Plans be comprehensive and include all funding sources channelled through the State Unit and Area Agencies on Aging to ensure that the planning and implementation process supports the development of community based long term care services.

5. Title III should be redefined under the heading "Community Based Long Term Care." References to individual services throughout the Act must be included as components of community based long term care systems. The Act should emphasize a continuum of care with linkages among services provided in the community, in the home, and in the institutions.

   Rather than planning for and funding individual services as separate activities, all services should be viewed as components of an overall community based long term care system linked together by case management. For those rural Area Agencies where limited services exist, it may be necessary to link the system through appropriate access mechanisms such as information and referral or other coordinating techniques. This approach allows for greater discretion at the local level in determining those most in need of services.

6. Title III should specifically mandate that Area Agencies on Aging:

   a. Develop a client-centered access system, either through direct provision or through contracts or other means, to assure the accessability of case management services as a primary component of community based long term care systems.

   b. Be responsible for coordination of federally and state funded services for the elderly through case management, resource management, and resource development.

   c. Retain and strengthen current advocacy responsibilities.

   These three mandated activities are necessary in order for Area Agencie[illegible] Aging to assume a more visible role in systems developm[illegible] and management. Area Agencies on Aging must carefully choose and target their activities so they may truly effect the development of a comprehensive community based long term care system.

7. OAA Title V and ACTION-OAVP funds should be administered by AoA. This administrative change is in keeping with the philosophy of integrating and coordinating all aging funds in support of comprehensive long term care systems. In addition, these resources can be used to enhance the informal and family supports necessary for an effective community based long term care system.

8. The OAA should target activities to the following groups:

   a. Persons in long term care institutions who are able to return to community living with sufficient formal and informal supports;

   b. Persons who are homebound;

   c. Persons who have limited mobility and are unable to carry out basic activities of daily living without assistance; and

   d. Persons without functional impairments by providing preventive services to maintain independence, e.g., health screening, nutrition, other senior center services, employment.

   The focus in the Act must be on the development of community based long term care systems that address the needs of frail and vulnerable elderly persons, at the same time providing preventative services for those elderly persons who are active in the community.

9. The Act should give special attention to minorities, special ethnic groups, and low income elders relative to their presence in the population. N4A strongly supports language recognizing the special needs of these groups to access long term care services.

10. The Act should mandate a sliding contribution scale based upon ability to pay to assure access to long term care services by all income levels. In addition, this mechanism would enable those who can afford to pay to do so.

    N4A supports this concept which allows all older persons access to a full range of community based long term care services, and to pay for such services accordingly. However, no older person shall be denied services because of an inability to pay.

11. The leadership role of the Administration on Aging (AoA) must be strengthened by elevating the agency to Assistant Secretary level within the Department of Health and Human Services (DHHS).

    The agency's ability to impact activities of other federal departments and agencies and the internal offices of DHHS would be increased and would provide visibility needed at the national level to advocate for the development of community based long term care systems.

12. The requirement for a single organizational unit at the Federal, State and Area Agency levels responsible for administering the OAA should be provided for in the Act.

13. The Act should allow Area Agencies on Aging access to a sufficient portion of the funds they administer under the OAA for the purpose of administration and management.

    With increased responsibilities for developing community based long term care systems, this flexibility is necessary to ensure an effectively administered OAA program.

14. The Act should mandate that Title IV-A State training funds be channelled to Area Agencies on Aging and utilized as a resource to provide training to strengthen the network's ability to develop community based long term care systems.

15. The Act should mandate the State Units on Aging to consider the views of Area Agencies on Aging, older persons and provider agencies in planning and operating the statewide long term care ombudsman program.

    This requirement would assure a more coordinated approach to strengthen the effectiveness of the statewide long term care ombudsman program.

With these changes, N4A feels this nation can move toward developing more effective and efficient community based long term care systems. These changes would not only provide the OAA Network on Aging the necessary authority but also assure that an adequate array of services are available and provided to older persons who are in greatest need across the country.

B. Other Legislation

The National Association of Area Agencies on Aging strongly supports the inclusion of the following general principle in all legislation directly affecting older people:

> To sustain older persons in their own homes and communities appropriately through the provision of an array of community based long term care services.

This goal will signify the introduction of a more humane and responsible approach to addressing the needs of older persons in non-institutional community based settings. It is important to note than N4A considers institutional care to be an appropriate long term care service for individuals who cannot be cared for adequately in their homes. Our concern stems from circumstances in which institutional care is the only service made available.

1. Medicare - Title XVIII. Medicare is federally administered and financed for all persons eligible for Social Security payments, without respect to income. The program has two components: Part A - Hospital Insurance Program, which is financed with Social Security Trust Funds and through employer and employee contributions. This covers inpatient hospitalization, skilled nursing care, and medically necessary home care. Part B - Supplementary Medical Insurance Program is a voluntary program financed through federal revenues and monthly premium charges for enrollees. This covers physician services, outpatient therapy, medical equipment, and home health visits. Both Parts A and B require beneficiaries to pay deductibles and co-insurance charges.

   Although Medicare is the primary health insurance program for the elderly, it covered only 44 percent of the total per capita health care costs in 1978; 29 percent were paid out-of-pocket by the elderly, and 27 percent by private insurance. This is primarily because of the failure of Medicare to cover long term care services, out of institution drugs, dental care, eyeglasses, hearing aids, and other important services needed by the elderly. Of the total Medicare expenditures for 1981, 72 percent were spent on hospital services and 22 percent on physician services. The remaining six percent went to nursing homes (less than one percent), home health (one percent), and other services (four percent). The strict enforcement of Medicare rules has severely limited coverage to services classified primarily as acute care for persons who can be rehabilitated. Those nursing home services (extended care) that reduce acute care stays are the only nursing home services allowed.

   The greatest potential of the current Medicare program is through integration with other financing programs. But there are no requirements that Medicare providers coordinate with community based long term care system brokers. For these reasons we are proposing the following changes:

   a. Facilities providing Medicare financed community based care should be required by statute to coordinate with local Area Agencies on Aging to assure service integration.

   b. Congress should support by statute the expansion of current Medicare waivers to allow for increased non-institutional, community based long term care services, such as home health aide services, adult day care and chore services.

   c. The Department of Health and Human Services should adopt a more flexible policy in granting permission to states for using Medicare waiver funds to support community based and in home services.

d. A larger portion of Medicare funds should be appropriated specifically for community based long term care services, i.e., maintenance, skilled nursing care, homemaker, home health aide, case management, adult day dare, respite, drugs, hearing aids, dentures, and eyeglasses. Provision of these services must be locally coordinated through Area Agencies on Aging, in their role as community based long term care managers and brokers. In addition, development of new services currently not available under Medicare, focusing primarily on non-institutional community based long term care services, should be allowed.

e. There should be no increased Medicare cost sharing, for this especially has an impact on our nation's low income elderly. Rather, emphasis should focus on incentives which would stimulate private insurance companies to incorporate wider coverage for community based long term care services, the development of Health Maintenance Organizations (HMO's), and other similar incentives.

f. N4A supports medical cost containment measures and believes cost containment can be achieved without compromising quality of patient care. The Diagnostic Related Group payment plan recently enacted by Congress is a positive step, but we are concerned that older people may be inappropriately discharged from hospitals to reduce costs. Such early discharges would create further problems for an already inadequately funded system of community based home care services. N4A recommends that existing requirements for Medicare Utilization Review be maintained and that the OAA contain authorization for a patient ombudsman to become a part of the Utilization Review process to assure maintenance of the quality of care for Medicare patients.

2. Medicaid - Title XIX. Enacted in 1965 to provide Federal matching funds for state programs in order to pay for medical services to low-income individuals and families, Medicaid is a state administered program jointly funded through federal and state taxes, with eligibility based on income. Individuals or families eligible for Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC) are automatically eligible for Medicaid. In addition, states can choose to cover categories of individuals designated as medically needy.

Federal regulations require that state Medicaid programs provide hospital insurance, physician services, skilled nursing facility care, laboratory and x-ray services, home health services, hospital outpatient care, family planning, rural health clinics and early and periodic screening, in addition to providing other optional services. States assert fiscal control over the program mainly by changing program policies such as eligibility standards, scope or duration of services covered, utilization controls, and reimbursement rates.

The 1981 Omnibus Budget Reconciliation Act included a number of changes in both Medicaid and Medicare. Aside from the three percent reduction in the federal share of Medicaid expenses for fiscal year 1983, states were given greater flexibility (Medicaid waivers) in respect to coverage and service provided under Medicaid. This provision has provided an opportunity for States and Area Agencies on Aging to become more involved in the provision of community based long term care services, even though 85% of the funds continue to support general hospitals, nursing homes, physician services and prescription drugs, and only 15% goes for all other Medicaid services.

N4A proposes the following changes in the Medicaid program in order for it to be more responsive to community based long term care systems:

a. State Medicaid officials should be required to work with the State Unit and Area Agencies on Aging to study the feasibility of redirecting additional Medicaid resources for the support of more comprehensive community based long term care services.

b. States should be legislatively mandated to coordinate with Area Agencies on Aging in developing and implementing Medicaid waivers.

c. Providers of community based long term care services funded by Medicaid should be legislatively required to coordinate with Area Agencies on Aging to ensure service integration.

d. Federal mandates should be imposed on states to assure that access services including case management and assessment are included as components of community based long term systems utilizing Medicaid funds.

e. Personal care should be mede a mandatory service.

f. There should be no further cuts in the Medicaid budget, for federal reductions are not the answer to health costs containment. Instead, reimbursement should be directed to those services which are appropriate and cost-effective.

3. Social Service Block Grant - Title XX. The Social Services Block Grant provides funds to states for social services for low income persons who meet eligibility requirements. This state administered program allows for state discretion for local service provision. In 1980, approximately $600 million was budgeted for community based services. Although some State Units and Area Agencies on Aging have been successful in achieving integration of this program with other programs serving the elderly, there has been no specific legislative mandate that these services be coordinated and integrated into community based long term care systems.

Based on this experience, N4A recommends the following changes in the Social Services Block Grant:

a. The authorizing legislation should be amended to require states to consider the views of older persons and Area Agencies on Aging when allocating Title XX funds for programs affecting older persons.

b. The authorizing legislation should also be amended to require states to channel funds allocated for aging programs through Area Agencies on Aging included as part of their Area Plan.

4. Supplemental Security Income - Title XVI. Supplemental Security Income (SSI) is a federally funded program which provides income maintenance to persons who are over 65, blind, or disabled, and whose assests fall below federal poverty standards. There is a minimum federal payment level, but states have the discretion to establish state supplemental payments and eligibility standards. While most states provide supplementary benefits ranging from $85 in Maine to $231 in California in 1983, some do not provide any supplements. If the program were entirely administered by the federal government the difference among states could be eliminated. N4A feels that the most serious problem with SSI levels is that, even with state supplementation, they are inadequate to meet the basic minimum living standard for food, clothing, shelter, and energy in all but a few states. Any restrictions or delays in cost of living increases in SSI payments will increase the demand on an already limited supply of community based long term care services as well as reduce the availability of boarding home care as a viable housing option for many elderly persons. Therefore, N4A recommends the following changes in order for the program to be more responsive to the development of community based long term care systems.

   a. The authorizing legislation should be amended, requiring offices locally administering SSI funds to coordinate with the Area Agency to ensure comprehensive service integration.

   b. The federal SSI payments should be increased by 25 percent to bring them in line with established poverty levels.

5. SSA - Old Age, Survivors, and Disability Insurance. N4A supports the recommendations of the National Commission on Social Security Reform which have recently resulted in major changes in the OASDI legislation. We further support an amendment to the authorizing legislation mandating the Social Security administrative network to work with AoA, State Units, and Area Agencies on Aging to facilitate greater coordination and ensure service integration at the local level.

6. Housing - Section 202. The Department of Housing and Urban Development (HUD), Section 202 program includes loans for housing for the elderly and handicapped, with some facilities offering special resident services.

   Because housing and alternative living settings are essential components of community based long term care systems, N4A supports the following changes in the Section 202 legislation:

   a. Regional and local housing authorities should be mandated to coordinate with Area Agencies on Aging to assure service integration at the local level. Further, supportive services should be mandated as a part of Section 202, particularly those services which facilitate access to community based long term care systems.

   b. Regional and local housing authorities should be mandated to coordinate with state and local transportation programs to assure access to transportation services for the residents of HUD-202 facilities.

7. Other Federal Programs. Legislation providing for energy assistance, food stamps, veterans' programs and other services for elderly persons should mandate coordination at the state and local levels with the Network on Aging.

VI. CONCLUSION

The adoption of this statement by the N4A Board of Directors during May, 1983 establishes the framework for the Association leading up to the 1984 reauthorization of the Older Americans Act. Our strategy will focus on a board dissemination of this statement and establishment of appropriate task forces to address implementation details.

N4A will also develop a strategy for dissemination and discussion of the statement with member Area Agencies, focusing on state-wide and regional meetings. Likewise, the 1983 N4A/NASUA Annual Conference, "Building Long Term Care Systems: The Aging Network's Agenda, will address the issue in detail.

APPENDIX A

BREAKDOWN OF HEALTH/SUPPORTIVE SERVICE ACTIVITIES AS REPORTED BY AREA AGENCIES ON AGING

Community Based Care

- Housekeeping
- Chore
- Personal Care
- Assessment
- Visiting
- Transportation
- Referral
- Telephoning
- Information
- Client Finding
- Escort
- Counseling
- Shopping
- Advocacy
- Supervision
- Evaluation
- Recreation
- Meals
- Placement
- Repair/Maintenance
- Letter Writing/Reading

Health-Medical

- Transportation
- Assessment
- Personal Care
- Diagnosis
- Treatment
- Escort
- Physical Fitness
- Counseling
- Referral
- Information
- Housekeeping
- Evaluation

Case Management

- Referral
- Assessment
- Counseling
- Information
- Evaluation
- Advocacy
- Client Finding
- Escort

Institutional Care

- Ombudsman
- Advocacy
- Placement
- Visiting
- Counseling

Health-Mental

- Counseling
- Assessment
- Treatment
- Visiting
- Diagnosis
- Telephoning
- Physical Fitness

Adult Day Care

- Supervision
- Meals
- Transportation
- Recreation
- Counseling
- Assessment
- Physical Fitness
- Personal Care
- Information
- Referral

Health-Dental

- Treatment
- Diagnosis
- Assessment
- Transportation
- Referral

QUESTIONS FOR MR. STEVE FARNHAM FROM SENATOR CHARLES E. GRASSLEY

1. The purpose of this first question is to just clarify the N4A position on an important issue. And then I would like to ask a follow-up. When the statement was released in July, it said on page 10, point b that Area Agencies on Aging were to be "responsible for managing and coordinating all federally and state funded services for the elderly..."

First, is it correct that this is no longer the precise position of N4A on this point?

2. Now let me ask about the present position whether it really differs that much. When you say "be responsible for coordination of federally and state funded services for the elderly...", which is the new language, what do you envision? Don't you need a grant of authority to do this, or couldn't this language be viewed as a grant of authority to do it, and wouldn't this get you involved in some of the same problems you wanted to avoid when you changed the language?

3. I think you have taken the position that authority for how long-term care services are administered, coordinated and provided should rest at the local level. The preceeding panel took a different tack.

Are we talking about different aspects of administration here, or do we have a real difference of opinion? Just how do you see the relationship between what the state should do and what local government or area agencies should do in the way of organizing and administering long-term care services?

4. Will a substantial investment of money or staff effort by area agencies in case management and assessment activities detract from the ability of triple-a's to plan, broker and coordinate services, particularly in light of the fact that major new resources will probably not be available for the Older Americans Act?

5. In our hearing last July on building long-term care systems, William Weissert pointed out that community care systems raise a whole host of new problems and dangers. He asked whether quality assurance in the community care systems could best be handled by the traditional quality assurance agencies or the area agencies. Were the triple-a's to handle this would they be required to acquire new skills, staffing and responsibilities? Do you think that they are the logical agencies to do this? If so, how would they do it?

6. What has been your experience in dealing with the mental health problems of the elderly? Have you had relations with community mental health centers, and if so, how would you characterize these relations? Do you think that area agencies should have a major responsibility in helping to provide mental health services for older people?

7. I am concerned to hear that the prospective payment system may be having negative consequences for older people in Maine, which I think was one of the points you were making. Dr. Patten thinks that triple-a's should monitor these developments.

How could area agencies help us with understanding what is going on here, and beyond that, what can we do about it?

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RESPONSES

1. The Older American's Act has established AAA's as the local agent of the Federal government in the coordination of services for the elderly granting authority for the development of service systems to meet their needs. A natural evolution has lead AAA's into the development of long term care systems and an increased targeting of services to those in greatest need, that population group threatened with institutionalization. As Mrs. Kane pointed out in previous testimony successful development of long term care systems requires, as the core, a case management system which can control required services and access of clients into the system. She pointed out certain lessons learned in her ten years of study of long-term care and the N-4-A position follows closely her recommendations based on the Canadian experience in British Columbia and Manitoba.

2. Our perspective on this issue again relates back to the development of a community based system of long term care. We view this system as a negotiable continuum of care encompassing preventative, in-home and institutional care. All services within this continuum should be responsive to individual client/family needs. Unfortunately this is not the case at the current time and we find that the system is based on forcing clients and their families to adjust to agency roles. It is sometimes like trying to fit square pegs into round holes, things just don't fit.

   We believe, and Mrs. Kanes research bears this out, that case management systems can make allocations of services in an equitable fashion responsive to client/family needs and the development and operation of this system can be cost effective. We believe AAA's are excellent organizations in which to vest this authority as we are elderly- centered and, as non-providers, have no vested interest in any part of service delivery. We have the ability to maintain a balance between being advocates for older people and responsible managers of the community's resources.

3. I don't believe we have a real difference of opinion on the basic goal, development of a long term care system that is responsive to people's needs. The State certainly has a primary role in establishing policy relative to long term care systems. They have a role in establishing definitions of service and establishing how those services are going to be paid for. The State must be responsible for standards of quality care and assuring that these standards are met. The AAA's strength is in knowing the local realities of multiple service systems and the complexity, both political and regulatory, of providers at the local level. We have an established relationship with providers and are recognized by older people and others in the community as the resource center for elderly concerns. Many AAA's have established themselves, as we have done, as the central figure at the local level in long term care system development.

   The issue isn't an "us or them" decision. We in the Aging Network - Federal, State and local level agencies, have a tradition of partnership and a history of working together. Few other "players" in the system enjoy such a past history. If one studies the positions taken by the State government representatives earlier and the N-4-A position one will find few major differences. We have tried to build in an assured role for AAA's and we have sought to strengthen the role of State Units on Aging at the same time. What we must address in the Act is a commitment of the Federal government to community-based long term care and we can work in partnership to see that it happens.

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4. I can speak from experience and say that development of a case management capacity does involve a shifting of AAA priorities and funding. The case management role does not take away from the capacity to broker and coordinate services rather it enhances and strengthens this role. The planning function becomes more focused, especially in regards to the needs of the frail, economically deprived and socially isolated. Development of a case management capacity by necessity forces a AAA to develop alternate resources to pay for this new service.

   The past use of Title III-B funds, indeed the intended use, has been to provide a gap filling function in the service system. It would not be appropriate to pull these resources for a role such as case management over the long term. Case management is a response to the needs of older people and their families yet long term care system development with case management at the core is a response to an impending crises precipitated by costly institutionalization. We must look to the prime fund sources of long term care services, Medicaid and Medicare, as new resources for AAA's. We can look at this as an investment in helping to curtail future cost increases in what seems to be an uncontrolable institutional system.

   III-B has been neglected for to long and it needs to be strengthened with additional funds. The gap filling role is increasing as new gaps are created as a result of Congressional actions like Medicare cost containment. The DRG system which is being implemented results in a counter affect at the community level. A corresponding increase in less expensive community or in-home care is required. III-B has been the major innovator in the past of such community and in-home alternatives and we now need more direct support.

5. Again an "either us or them" situation is being assumed. AAA's have long funded in-home services such as homemaker and home health aides, skilled in-home nursing and other services. We have established standards of quality for these contracted services and I am not aware of many complaints. Most States have quality assurance mechanisms built in through licensing and certification and the community based system of long term care that we advocate for does nothing to alter existing quality assurance mechanisms. Indeed, a case management system can serve to point out inadequacies in current quality assurance mechanisms and can utilize the advocacy function of the AAA to strengthen standards.

6. We have an excellent relationship with our local mental health center and have found them responsive to the mental health needs of older people. Their agency has the same problem we have in terms of developing new or special programs and services, new financial resources are hard to come by in rural areas and it is a struggle to maintain what you have.

   The AAA role in helping to provide mental health services lies in identifying the mental health needs of the older population. In terms of a major responsibility to fund services to provide for those identified needs the answer is simple, current III-B resources are inadequate to do so.

7. Area agencies should monitor the implementation of the DRG system and especially be aware of an increasing need for community and in-home care. We can work with hospitals and home health agencies in identifying problem areas.

   Area Agencies on Aging have already identified what Congress can do about it. The problems surrounding DRG's and what to do with people that need supportive care are not new ones. We have suggested that the Older American's Act establish a community based long term care system with case management at the core and this is part of the answer. We need an integration between institutional and community systems of care, coordination of all care and a national commitment to this type of policy.

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Senator **Grassley**. Thank you.

Senator Hawkins for questions or comments?

Senator **Hawkins**. I appreciate your testimony. Just a question to both.

Would you still support the legislative mandate for long-term care if no additional funds were available?

Mr. **Fagan**. Yes.

Mr. **Farnham**. It wouldn't be that simple. It would be very difficult. We would support, of course, the language, but I think Mr. Rowland from Massachusetts said that the language, without additional funding resources, or at least the ability to tap into funding resources, such as medicare and medicaid, and maybe some increased influence over social service block grant money it would be very difficult to implement the system, but it is operating in many States simply because those States and area agencies in those States have taken the initiative to see that it happens. But we do need more money.

Senator **Hawkins**. Thank you.

Senator **Grassley**. Senator Pell, I want to introduce you here to this group and thank you for coming, and appreciate your participation.

Senator **Pell**. Thank you very much, and I congratulate you on holding this hearing and permitting me to hold a hearing on your behalf in Rhode Island a few weeks ago. I would just say how important this whole subject is, particularly as to aging. I am following the work all I can, perhaps brought on by the fact that I just achieved the age of 65 myself.

Senator **Grassley**. You are brave and exceptional to talk about it. Thank you.

Well, thank you for coming, and I do have one or two questions I would ask. They do not involve long answers.

Given that States like Maine, Washington, and Iowa, and in the State units or area agencies either have or will soon have major responsibilities and leadership role in long-term care, given this present extensive involvement on the part of some State and area agencies, why are substantial changes in the act required?

Mr. **Farnham**. The changes that we envision in the act, we do not believe are substantial changes. We believe the suggested language changes are really a catching up process for the Federal legislation with what in reality is happening out in the field, and it would give us what we feel is a clearer mandate and a cleaner base for operations back at the local level if we saw the Older Americans Act language adjusted to reflect what is actually needed and happening.

Senator **Grassley**. Mr. Fagan, the implication of your statement was that locally elected officials, and I emphasize locally elected, should be ultimately responsible for determining how these services are provided, contrasted, I suppose, with organizations not run by elected officials.

Can you expand a bit on this point and particularly from the standpoint of the 264 area agencies that are not local governments?

Do you see a need to change the relationship with the elected officials?

Mr. **FAGAN**. I think it is important that the local legislative and executive functions have an option as to whether they want to be involved in area agency activities or not. The present act encourages participation of local elected officials in the activities, particularly the development of the plan of the area agency on aging. It is the position of NACo that counties should be given the option as to whether they would exercise the functions of an area agency or not.

I think what you will find is that some counties would exercise that option. Most counties that are not currently exercising that option will continue to maintain or enhance other kinds of relationships with the area agency on aging. Right now that is not a mandated part of the act.

Senator **GRASSLEY**. OK. I would also like to give you a chance, Mr. Fagan, if you would like to expand on ways that the Older Americans Act could help counties in providing long-term care services.

Mr. **FAGAN**. Well, you know, it is curious to use the term "long-term care" in regard to older Americans when, in fact, if you look at the statistics on the average time that an older person spends in an intensive skill long-term care setting, it is probably not more than 3 or 4 years. Long-term care is something that applies more broadly to special populations that are born with or incur a particular chronic condition when they are much younger.

It would seem to me that we have a semantics issue here. Just as important as the need for intensive sophisticated and continuing intervention with medical resources is there is just as much a need to provide what I am going to call light protective services from resources under the Older Americans Act. So when we talk about expanding the application of the Older Americans Act, I think we are talking about discovering that "long-term care" begins with early intervention, with identification of and light supports for the highly at risk population, and with a lot of preventive kinds of things that lead to self help as opposed to focusing exclusively on expensive mechanical/institutional care.

Senator **GRASSLEY**. Thank you very much.

Yes, Senator Pell.

Senator **PELL**. I have just one question I would like to interject here.

That is, I was in Soviet Georgia some months ago. I talked with a group of older people, all over 100, vibrant and vigorous, and I was struck by the fact that the life they lived is not an impossible life for people over here to lead. One of the most important points they felt was the fact that they remained part of the family group. Maybe the job is not a major job, feed the chickens, something like that. And I brought this up in hearings here, when the chairman permitted me to hold the hearings in Rhode Island, I remember asking a group of senior citizens how many of you would prefer to be in a nice free from vandalism homes for the aged, how many of you would like to be in the hurly-burly of your children and grandchildren? I was very struck, that four-fifths of those hands went up saying they would rather be in the hurly burly with their children and grandchildren rather than more antiseptic surroundings.

What we are really talking about here is the quality of life and not just the prolongation of life. I was interested in your reactions to this.

Do you think older people in general have the same reactions as I found when I asked my particular group this question, and what do you think accounts for the fact that, instead of achieving 70 or 80, that the people in that part of the world achieve 100?

Mr. FAGAN. I do not have any precise research data on the social circumstances that older people would choose or not choose.

The best information that I have ever seen on this comes from work that was done at the Philadelphia Geriatric Center. They broke the older population into thirds. Approximately a third of the study population wanted to remain in an intensive community family setting. Another third wanted to be selective. In other words, a lot of older people love the interaction with family to the extent that they have some choices. I think my mother is a good example of someone who loves her grandchildren, but looks forward to getting away from them at the end of the day as well. And then there is another third of the older folks that tend to gravitate together and to shut out the rest of the world in senior citizen retirement communities and in a segregated setting. I think the point here is that the older population is diversified, certainly quality of life is a very critical part of that; choice is a very important part of quality of life, and certainly we are exercising value judgments when we say that one is preferable to the other.

But I think that what you find, is that it is important to have choices and it is important that each of these options is there and includes the opportunity for support and participation, whether it comes from family or community or friends or neighbors, that is what generates the quality of life dimension.

Mr. FARNHAM. I was somewhat fortunate because a few years ago I had the opportunity to visit that same part of the world. One of the things that struck me was like Maine, at least a part of Maine that I am from, that part of Georgia has a basis in agriculture, and there is no defining a retirement role for a lot of those people that you are citing. They are just expected to work. They are productive and a continuing part of the community, and retirement is kind of a foreign term to them. Maybe we have something to learn from that, I am not sure.

In our State, what you said is certainly true. The support for the kind of home care services that we have and the system of services that we have developed grew from that, I believe from older people, the ability to remain in their own homes with their families.

One of the things that is unique to the system of management that you see attached to my statement is when I am talking about case management, we are talking about management of care and the basis of that management of care, sitting down with that person who is having a functional problem, those are the people providing that care, they are going to be the difference whether that person goes to an institution or not, and in looking at what that family's needs are, in terms of providing that structure for them and our role is really assistance to that family. They cannot negotiate all those services that we put out there and all the eligibility requirements and everything else. I cannot do it. I am a professional person in the field. I doubt that you can do it. You are a Senator.

So what our care managers do, they define that system based on what the family's needs are. They take care of all the paperwork and the eligibility guidelines and everything else and put the systems and services there to support that family unit. And beyond that, they monitor those services and make sure that they continue to be provided in an adequate way to maintain that family structure. And when it finally gets to the point where the system is breaking down because that care is not there, then the transition is into institutions, but that is the basis of our system. We really see more family support systems than anything else.

Senator **Pell**. Thank you.

Senator **Grassley**. Yes, that is an important consideration that we ought to think about quite often, not only in this committee, but as many committees as we try to make public policy. Sometimes we discourage people from being productive citizens.

I want to thank you, Mr. Fagan and Mr. Farnham, for your participation, and I think Senator Pell's question makes it real easy for us now to move on to our fourth panel and get a little different point of view.

I would like to remind the subcommittee and the audience that we held hearings into the treatment of Alzheimer's disease and we subsequently sponsored two briefings for interested Senators and staff. Today we will hear about the mental health services for the elderly through the Older Americans Act Aging Network and through the community mental health center.

Our first witness obviously needs no introduction, Dr. Arthur Flemming. I first met him when I was appointed as a member of the then new select committee on aging, and I have had an opportunity every year since I have been in the Congress to have dialog with him as a Member of the Congress and from his expert point of view, and also as a public witness. He is a former Secretary of HEW, also the evolution of the Older Americans Act was influenced by his leadership as commissioner on aging for a long period of time. And I welcome you here, Dr. Flemming.

Also I would like to say that our second witness is Dr. Mary Carman from Newton, KS. Dr. Carman runs one of the most successful mental health programs for the elderly in the country, and she is going to speak also on behalf of the National Council of Community Mental Health Centers.

I also would like to recognize Joan Buchanan, the staff director for the action committee which Dr. Flemming is representing in his testimony here today.

So, Dr. Flemming, would you proceed, and then, Dr. Carman, and do you have anything you are going to say, Ms. Buchanan?

Ms. **Buchanan**. No.

Senator **Grassley**. All right.

Dr. Flemming.

STATEMENTS OF DR. ARTHUR FLEMMING, ACTION COMMITTEE TO IMPLEMENT THE MENTAL HEALTH RECOMMENDATIONS OF THE 1981 WHITE HOUSE CONFERENCE ON AGING, REPRESENTING THE AMERICAN NURSES ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, AND NATIONAL ASSOCIATION OF SOCIAL WORKERS; AND JOAN BUCHANAN, ACTION COMMITTEE STAFF MEMBER; AND DR. MARY CARMAN, DIRECTOR, DEPARTMENT ON AGING, PRAIRIE VIEW, INC., NEWTON, KS

Dr. FLEMMING. Senator Grassley, thank you very much. I appreciate the opportunity of appearing before you and the members of the committee in connection with what I regard as a very important issue.

Personally, over the years I have felt that our society has seriously neglected the area of mental health when applied to older persons. Consequently, I welcome the opportunity of joining with a group of professional people in the field to address this issue. I am chairman of this Action Committee, but I am a layman and all the other members of the committee are professionals. But I am very, very happy to be a part of their work.

This committee was established by a grant from the Retirement Research Foundation as an interdisciplinary body concerned with the financing, organization and delivery of mental health services to older Americans.

I also like the title of the Action Committee because as one who has been very much involved in White House conferences on aging I am very, very happy when a group of people decide that they are going to go to work on trying to implement the recommendations that came from the White House Conference on Aging. Because so often the recommendations are made and then sometimes tend to gather dust.

In my testimony I have identified the organizations that I am representing, but in the interest of time I will summarize my statement. But I would like to make the request, Mr. Chairman, that the full text of my testimony be included in the record.

Senator GRASSLEY. Yes, without objection.

Dr. FLEMMING. And I will just summarize the testimony.

The mental health needs of the elderly are well documented. Although older adults constitute slightly more than 11 percent of the total U.S. population, they account for nearly 20 percent of national suicides. Further, 15 to 25 percent of Americans age 65 or over experience some symptoms of mental illness in later life. As many as 30 percent of this group develop some form of depression. And the National Institute of Mental Health estimates that over 20 percent of this group are in nursing homes. Evidence of mental illness increases dramatically in nursing homes where 50 to 75 percent of the residents show significant emotional and behavioral dysfunctions.

The data that have been assembled on this particular issue are particularly disconcerting because most of these mental disorders are treatable and reversible.

Despite evidence that the mental health problems experienced by the majority of the aging population can be effectively treated and reversed, this population is not receiving appropriate mental health care. Overall, less than 1½ percent of all expenditures for mental health care is allocated to community-based services for older adults. That statistic comes from the work of the President's Commission on Mental Health task panel.

Under the current federally initiated services, Community Mental Health Centers are the designated community agencies providing mental health services to older adults as well as to younger populations. Yet taking the Nation as a whole, the Community Mental Health Centers are meeting the needs of only a few of the elderly.

While I was serving as chairman of the U.S. Commission on Civil Rights, the Congress directed us to make a study of the question of age discrimination in the delivery of services financed in whole or in part by the Federal Government.

One of the areas that we looked at very closely was the area of mental health. And as a result of that investigation and public hearings that we held in connection with the investigation, we concluded as a Commission that older adults were grossly underserved in comparison to other age groups by the federally supported Community Mental Health Centers.

This situation has not changed substantially, as is evidenced by a 1983 survey of the Community Mental Health Centers conducted by the Action Committee. The Action Committee survey, which was targeted toward nearly 700 of these centers found that the centers' aging clients comprise only 6 percent of the overall client population.

The pattern of underservice to the elderly in the field of mental health persists as a result of a combination of factors, it seems to me: Reimbursement structures under Federal health programs; the continued fear and stigma that still haunt our national conception of mental illness; and the fragmented, disorganized systems of mental health, health and social service programs for the elderly. Overarching all of these problems is the presence of ageism in institutions which deliver mental health services.

In the investigations conducted by the U.S. Commission on Civil Rights, the presence of ageism was clearly established.

As this subcommittee is aware, there are currently two exclusive service systems. The community mental health centers to which I have referred, and the services financed by the area agencies on aging which can potentially serve the psychosocial needs of the older persons. Unfortunately, these systems are currently structured as separate independent service systems. The community mental health centers serve only the psycho needs of the individual and the area agencies on aging, when they support mental health programs, serve only the social needs.

A recent study by the General Accounting Office, "The elderly remain in need of mental health service" found that many of the services which the mentally at risk elderly need are social supports, rather than or in addition to more traditional mental health interventions. That is a quote from that report. In order to accomplish this, the authors of the GAO study call for increased cooperation among primary care, mental health and social service providers, noting that they did not find such linkages to be well developed.

The Action Committee survey to which I have referred reconfirmed the GAO findings. In a series of site visits to community mental health centers and community-based area agencies on aging programs, the Action Committee found that there is little routine interaction between the two service systems. Such findings pose a major challenge to both the aging network and the mental health care system and should be carefully studied, it seems to me, by this subcommittee in its deliberations on the Older Americans Act reauthorization.

Congress has enacted a series of legislative incentives for the provision of mental health services to older adults. In 1975, specialized services for the elderly were targeted as an essential component of community mental health centers, which had been established in 1963. This requirement was reemphasized in the 1978 amendments to the Community Mental Health Centers Act.

Despite these congressional directives, the centers did not uniformly implement such services, although many outstanding programs were started during that period. In 1980, in an effort to encourage and strengthen a national program, the Mental Health Systems Act provided increased incentives for aging programs by providing community mental health centers and other private nonprofit mental health provider agencies with separate staffing and coordination grants to develop aging-specific programs.

However, the Mental Health Systems Act was never implemented due to enactment of the mental health block grant program. Although the block grant program does contains some provision for specialized service to the elderly, the Action Committee survey has found that since the block grant program was implemented there has been a marked decrease in community mental health center aging programs. Sixty-four percent of those responding to the survey indicated that they once had, but no longer had, aging programs. The survey indicated that the termination rate for such specialized programs has increased sharply since 1980.

Thus, at this time it is apparent that the community mental health centers are not able to play a leadership role in shaping and delivering mental health services to older people.

The 97th Congress in enacting the 1981 Older Americans Act amendments put in a section in title IV of the act requiring targeted mental health demonstration programs for older adults. Of course you are familiar with that particular section.

Despite the intentions of the Congress in enacting these provisions, the administration to date has not issued a grant announcement which incorporates the range of issues comprised in the 1981 amendments. Further, in review of the Administration on Aging Office of Program Development title IV active grants and contracts listing, we find only six awards since 1981 which reflect even the general intent of the mental health provisions.

The groups which I represent favor several recommendations which we believe would strengthen the act and provide older adults greater access to mental health and social support services.

I think I should underline the fact that we strongly favor the reestablishment of the Mental Health Systems Act with its provision providing for services for older persons. I think that must be recognized as one considers these recommendations.

We recommend that the subcommittee maintain and include in the reauthorization the above-referenced provision currently contained in title IV, part B, section 422(b). However, we suggest that the 1984 amendments provide for implementation of this section through the allocation of funds and the timely issuance of regulations and program announcements specific to carry out the intent of the act.

Then we recommend that title III of the act be amended to authorize area agencies on aging to contract and make grants to serve the social needs of the mentally ill elderly. Further, such an amendment should direct area agencies on aging to develop working agreements with community mental health centers and other public or private nonprofit organizations providing mental health services to assure a coordinated approach in meeting the mental health and the psychosocial needs of the elderly. Rather than requiring area agencies on aging to fund such programs out of existing funds, a separate appropriation should be provided for the operation of such programs.

We would be very happy of course to work with the staff to draft amendments designed to carry out these recommendations.

Again, Mr. Chairman, I want to express my own personal appreciation to you and the other members of the committee in deciding to turn the spotlight on this particular issue, the care of the elderly in the mental health area. It has been a neglected area and I feel that this subcommittee, the full committee and the Congress have an opportunity to do something about it.

I certainly appreciate the opportunity of appearing before you today.

[The prepared statement of Dr. Flemming and response to questions submitted by Senator Grassley follow:]

TESTIMONY OF

ARTHUR S. FLEMMING

On behalf of the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, the American Nurses' Association, the American Psychiatric Association, the American Psychological Association and the National Association of Social Workers, I am pleased to have this opportunity to comment on the mental health care needs of older Americans.

The Action Committee, which I chair, was recently established by a grant from the Retirement Research Foundation as an interdisciplinary body concerned with the financing, organization and delivery of mental health services to older Americans. Other Action Committee members include: John Santos, a psychologist from the University of Notre Dame; Chicago psychiatrist Sanford Finkle, Medical Director of the Barclay Hospital; Audrey Faulkner, professor of social work from Rutgers University; Elizabeth Carter of the Columbia School of Nursing, New York; Frankie Muse Freeman, St. Louis attorney; and Gary R. VandenBos of the American Psychological Association.

The American Nurses' Association, comprising 53 state constituent members, is the national professional organization representing the interests of the nation's professional nurses. The purposes of the ANA are to work for the improvement of health standards and the availability of health care services for all people; to foster high standards of nursing; and to stimulate and promote the professional development of nurses and advance their economic and general welfare.

The American Psychiatric Association is the nation's oldest medical specialty society representing over 28,000 psychiatrists nationwide. Among the objectives of the Association are: improving the treatment, rehabilitation and care of the mentally ill, mentally retarded and emotionally disturbed; fostering cooperation of all who are concerned with the medical, psychological, social and legal aspects of mental health and illness; and promoting the best interests of patients and those actually or potentialy making use of mental health services.

The American Psychological Association, representing over 72,000 members, is the primary national psychology organization. The Association is active in promoting responsive concern by the profession on a variety of social and public policy issues; disseminating psychological knowledge to enhance and increase human progress and well-being; developing standards of education, ethical conduct and professional practice; and promoting research by working to improve research methods and conditions.

The National Association of Social Workers is the largest organization of professional social workers in the world, with 90,000 members nationwide. The primary objectives of the Association include: advocating sound social policies and programs and promoting activities to ameliorate the effects of discrimination; creating professional standards for social work practice; and advancing social work practice through continuing education.

Our primary concern is the need for a coordinated approach to the delivery of mental health services to older people within the continuum of the long term care system. This concern is highlighted in nearly twenty of the White House Conference on Aging recommendations, and in numerous studies which will be referenced throughout these remarks. We recognize that this hearing is focused on the Older Americans Act. We believe the Act can and should serve as a legislative foundation for programs designed to reach many of the nation's elderly in need of information about and access to mental health and other health services, as well as the continuum of care offered by the social services network. However, before detailing our recommendations and concerns in this regard, we believe it is important to describe the population with which we are most concerned, and to point out some serious obstacles to meeting the mental health care needs of this population.

MENTAL HEALTH NEEDS OF THE ELDERLY

The mental health needs of the elderly are well documented. Although older adults constitute slightly more than 11 percent of the total U.S. population, they account for nearly 20 percent of national suicides. Further, 15 to 25 percent of Americans age 65 or over experience some symptoms of mental illness in later life. As many as 30 percent of this group develop some form of depression; and NIMH estimates that over 20 percent of this group are in nursing homes. Evidence of mental illness increases dramatically in nursing homes, where 50 to 75 percent of the residents show significant emotional and behavioral dysfunctions.

The foregoing data are particularly disconcerting because most of these mental disorders are treatable and reversible. The President's Commission on Mental Health noted that as many as 25 percent of those individuals determined to be "senile" actually have treatable, reversible conditions. Older individuals with some form of depression which is not related to physical disorders can be treated as effectively as with younger adults suffering comparable disorders. As with younger populations, treatment of such emotional disorders need not be long term or costly, and is most effectively provided on an outpatient basis. In some cases, physical disorders can produce depression and confusional states which are correctable and treatable conditions masquerading as organic brain syndrome. Early diagnosis and treatment of such disorders can minimize their impact, delaying or preventing a worsening of the physical and associated mental conditions.

UNDERSERVICE OF THE MENTALLY ILL ELDERLY

Despite evidence that the mental health problems experienced by the majority of the aging population can be effectively treated and reversed, this population is not receiving appropriate mental health care. Overall, less than 1.5 percent of all expenditures for mental health care is allocated to community based services for older adults. The President's Commission on Mental Health Task Panel on the Elderly found that the elderly are "unserved, underserved, or inappropriately served." These findings have been confirmed by the Health, Education and Welfare Secretary's Committee on Mental Health and Illness of the Elderly, the United States House of Representatives Select Committee on Aging's National Conference on Mental Health and the Elderly, the U.S. General Accounting Office, and a recent Action Committee Study.

Under the current federally initiated service system, Community Mental Health Centers (CMHC's) are the designated community agencies providing mental health services to older adults, as well as to younger populations. Yet, CMHC's are meeting the needs of only a few of the elderly. The Age Discrimination study conducted by the U.S. Civil Rights Commission in 1978 found that older adults were grossly underserved, in comparison to other age groups, by federally supported CMHC's. This situation has not changed, as is evidenced by a 1983 survey of CMHC's conducted by the Action Committee. The Action Committee survey, which was targeted toward nearly 700 CMHC's, found that CMHC's aging clients comprise only 6 percent of the overall client population.

This service pattern is also reflected by data on private mental health practice and nursing homes. Overall, private practitioners provide only 3 percent of their services to older clients. And, fewer than 1 percent of nursing home residents have access to psychological or psychiatric assessment and treatment.

FACTORS CONTRIBUTING TO UNDERSERVICE

The pattern of underservice to the elderly persists as a result of a combination of factors: reimbursement structures under federal health programs; the continued fear and stigma that still haunt our national conception of mental illness; and the fragmented, disorganized systems of mental health, health, and social service programs for the elderly. Overarching all these problems is the presence of ageism in institutions, which deliver mental health services. While we recognize that several of these issues may not fall within the Subcommittee's jurisdiction, we believe an overview of the problems is essential to an understanding of the impediments to mental health care for older Americans.

Federal Reimbursement System

In considering federal reimbursement systems for mental health care, it has been and remains a tragic commentary that today's Medicare system fails to assure that individuals should "have their suffering alleviated insofar as possible," as recommended by the President's Commission on Mental Health. This Subcommittee as well as the Senate Finance Committee must come to grips with the fact that Medicare has institutionalized the bias against those suffering from nervous and mental disorders in its harsh and uniquely discriminatory coverage of mental health benefits. Under Medicare, the outpatient treatment of the elderly's physical disorders is not limited by dollars; but if the disorder is mental, coverage ends after a Federal share of $250 per year is reached. Further, the Medicare Part B coinsurance requirement for mental health care is 50 percent, as opposed to the 20 percent requirement for physical health care. Similarly, inpatient treatment of a physical disorder is not subject to day limits; but if the disorder is mental, a 190 day lifetime limit is imposed. Medicare's failure to provide adequate coverage for the treatment of mental disorders is not within the purview of the Subcommittee. However, we believe it is important that the Subcommittee recognize that this barrier to adequate health care for the mentally impaired elderly stands in the way of many of our mutual goals.

Stigma of Mental Health Care

The Subcommittee can help make a difference in another area which serves to segregate the elderly with mental and emotional prolems from the health care and social services networks — the continuing stigma of mental illness. Due to the stigma popularly attached to mental illness, and due to their private fears relating to it, most people are reluctant to seek mental health care. Indeed, the person with an emotional disorder is more likely to delay or reject early treatment for their complaint than they would be to seek help for a physical disorder. Add to this the fact that today's elderly belong to a generation that has traditionally viewed mental illness with an almost superstitious dread. To many older adults, senility is perceived as a normal aspect of aging; to be gloomy and without hope for the future is considered a natural state, not a manifestation of depression. Moreover, it is often assumed that the mentally healthy older person grows more pessimistic, rigid and irascible with age. Such erroneous belief structures must be erased. It is essential that we work together to eliminate the stigma of mental illness by placing it in its proper perspective. Namely, we must recognize that emotional disorders can be ameliorated and treated in the same way as many physical difficulties. Until we can accomplish such recognition, we will continue to be frustrated, not only in meeting the needs of those already suffering from mental disorders, but also by the vast numbers of individuals who are too proud or too frightened to accept the fact of mental disorder and to seek and receive treatment. The existing network of Area Agencies on Aging established under the Older Americans Act can help bridge the gap between these self-defeating beliefs and access to both the mental health treatment and social service networks.

Fragmented Service Systems

As the Subcommittee is no doubt aware, there are currently two exclusive service systems, Community Mental Health Centers and services financed by Area Agencies on Aging, which can potentially serve the psycho-social needs of the older person. Unfortunately, these systems are currently structured ac separate, independent service systems. The Community Mental Health Centers serve only the "psycho-" needs of the individual and the Area Agencies on Aging, when they support mental health programs, serve only the "-social" needs. A recent study by the General Accounting Office, "The Elderly Remain in Need of Mental Health Service," found that "many of the services which the mentally at risk elderly need are social supports, rather than or in addition to, more traditional mental health interventions." In order to accomplish this, the authors of the study call for increased "cooperation among primary care, mental health and social service providers," noting that they "did not find such linkages to be well developed." Our own Action Committee survey reconfirms the GAO findings. In a series of site visits to CMHC's and community-based aging programs, the Action Committee found that there is little routine interaction between the two service systems. Such findings pose a major challenge to both the aging network and the mental health care system and should be carefully studied by the Subcommittee in its deliberations on the Older Americans Act reauthorization.

LEGISLATIVE HISTORY

Congress has enacted a series of legislative incentives for the provision of mental health services to older adults.

In 1975, specialized services for the elderly were targeted as an essential component of Community Mental Health Centers, which had been established in 1963. This requirement was reemphasized in the 1978 amendments to the Community Mental Health Centers Act. Despite these Congressional directives, CMHCs did not uniformly implement such services, although many outstanding programs were started during that period. In 1980 in an effort to encourage and strengthen a national program, the Mental Health Systems Act provided increased incentives for aging programs by providing Community Mental Health Centers and other private non-profit mental health provider agencies with separate staffing and coordination grants to develop aging-specific programs. However, the Mental Health Systems Act was never implemented due to enactment of the mental health block grant program. Although the block grant does contain some provision for specialized service to the elderly, the Action Committee CMHC survey has found that since the block grant program was implemented there has been a marked decrease in CMHC aging programs. Sixty-four percent of the CMHCs responding to the survey indicated that they once had, but no longer have, aging programs. The survey indicated that the termination rate for such specialized programs has increased sharply since 1980. Thus, at this time it is apparent that the Community Mental Health Centers are not able to play a leadership role in shaping and delivering mental health services to older people.

The groups I am representing today jointly endorse the premise that the services component of the Mental Health Systems Act (or comparable legislation) must ultimately be reinstated. However, in the interim we agree that the Older Americans Act should be recognized as a vehicle for encouraging and establishing necessary services for the mentally ill elderly.

The 97th Congress recognized this challenge in enacting in the 1981 Older Americans Act amendments (P.L. 97-115) a section in Title IV of the Act requiring targeted mental health demonstration programs for older adults. Section (Title IV Part B Sec. 422 (b)) of the Act specifies:

"(b) In making grants and contracts under this section, the Commissioner shall give special consideration to projects designed to --

(1) meet the special health care needs of the elderly including --

(A) the location of older individuals who are in need of mental health services;

(B) the provision of, or arrangement for the provision of, medical differential diagnoses of older individuals to distinguish between their need for mental health services and other medical care;

(C) the specification of the mental health needs of older individuals, and the mental health and support services required to meet such needs; and

(D) the provision of --

(i) the mental health and support services specified in clause (C) in the communities; or (ii) such services for older individuals in nursing homes and intermediate care facilities, and training of the employees of such homes and facilities in the provision of such services;"

Despite the intentions of the Congress in enacting these provisions, the administration to date has not issued a grant announcement which incorporates the range of issues comprised in the 1981 amendments. Further, in review of the Administration on Aging Office of Program Development Title IV Active Grants and Contracts listing, we find only six awards since 1981 which reflect even the general intent of the mental health provisions. Given the long term care orientation of these hearings, it is interesting to note that none of these grant awards are for mental health demonstration programs in nursing homes and intermediate care facilities.

It is, therefore, apparent that the 1981 Older Americans Act amendment is not adequate to stimulate increased attention to the mental health needs of older adults. We are accordingly, proposing that Congress enact more directive provisions for mental health in the 1984 amendments.

RECOMMENDATIONS

The groups which I represent favor several recommendations which we believe will strengthen the Act and provide older adults greater access to mental health and social support services.

First we recommend that the Subcommittee maintain the above referenced provision currently contained in Title IV Part B Section 422(b). However, we suggest that the 1984 Amendments provide for implementation of this section through the allocation of funds and the timely issuance of regulations and program announcements specific to carry out the intent of the Act.

Secondly, we recommend that Title III of the Act be amended to authorize Area Agencies on Aging to contract and make grants to serve the social needs of the mentally ill elderly. Further, such an amendment should direct Area Agencies on Aging to develop working agreements with Community Mental Health Centers and other public or private nonprofit organizations providing mental health services to assure a coordinated approach in meeting the mental health and the psychosocial needs of the elderly. Rather than requiring Area Agencies on Aging to fund such programs out of existing funds, a separate allocation should be provided for the operation of such programs.

We stand ready to provide Subcommittee staff with a draft amendment to carry out these suggestions.

We are pleased to be called upon to play an active role in advocating for the inclusion of these important and necessary provisions in the 1984 Older Americans Act Amendments. The Subcommittee is to be commended for their efforts on this major national initiative.

ACTION COMMITTEE
TO IMPLEMENT THE MENTAL HEALTH RECOMMENDATIONS
OF THE 1981 WHITE HOUSE CONFERENCE ON AGING

March 20, 1984

Honorable Charles E. Grassley
Chairman, Subcommittee on Aging
United States Senate
Washington, D. C. 20510

Dear Senator Grassley:

I was honored to have the opportunity to testify before the Subcommittee on Aging on "Long-Term Care under the Older Americans Act", and to comment on the mental health care needs of older Americans. Thank you for the interest and consideration which has been accorded our recommendations.

I am pleased to be able to respond to the questions you have posed related to my testimony for the hearing record. My remarks are as follows:

1. (Q) You cited a number of statistics on the extent to which older people are served by the Community Mental Health Centers and by private practitioners. Clearly, these figures would seem to indicate underservice. But these are rather general national figures. Are needs assessments at the local level used regularly to help understand the more or less precise magnitude of mental needs of the elderly in communities?

(A) There are currently no requirements that either Area Agencies on Aging or Community Mental Health Centers conduct needs assessments on the mental health needs of the elderly. In some states and communities we understand that this is being done; it is not, however, done on a uniform basis which would allow a more accurate assessment of local needs. As a step towards remedying this situation, I would recommend that the Subcommittee develop Older Americans Act amendments and allocate funds to enable Area Agencies on Aging to conduct needs assessments on the aged with mental health problems in their catchment areas.

2. (Q) You stated in your written testimony that the Administration has not issued a grant announcement which incorporates the range of issues identified in the 1981 Title V amendments. Could you characterize a bit more precisely the six awards made in the mental health area since 1981? Just what do they focus on and why don't they meet the present requirement of Title IV? Do you consider the long-term care gerontology centers and the work they do, and the channeling demonstrations as possibly meeting the concerns of those 1981 amendments?

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(A) The awards referenced provide for: 1) the establishment of a model for effective collaboration between aging and mental health networks to increase accessibility of the elderly to a full range of mental health services; 2) increasing mental health and aging services coordination to create acceptable, accessible, cost-efficient, and replicble peer counseling models within the framework of current service systems; 3) facilitating mental health and aging interagency linkages through replicable methods of knowledge transfer and information dissemination; 4) design and testing of a management information system; 5) comparing effectiveness of widowers self-help groups; and 6) developing a client management system on guardianship care. All of these projects are useful. Collectively, however, they fail to address in a significant manner some of the stated objectives of Title IV. For example, the Commissioner is directed in Title IV to give special consideration to projects designed to:

> "(1) meet the special health care needs of the elderly including --
>
> (A) the location of older individuals who are in need of mental health services;
>
> (B) the provision of, or arrangement for the provision of, medical differential diagnoses of older individuals to distinguish between their need for mental health services and other medical care;
>
> (C) the specification of the mental health needs of older individuals, and the mental health and support services required to meet such needs; and
>
> (D) the provision of --
>
> (i) the mental health and support services specified in clause (C) in the communities; or (ii) such services for older individuals in nursing homes and intermediate care facilities, and training of the employees of such homes and facilities in the provision of such services;"

We believe that if the Commissioner had issued a grant announcement covering the range of issues that are in Title IV, proposals would have been submitted, which if funded, would have made a contribution to dealing with all of the issues. This seem to us to have been the clear intent of the Congress.

3. (Q) Would you say that the primary care for the mental health of the elderly rests with the mental health system proper, rather than with the Older Americans Act network?

(A) As set forth in my testimony, we believe that Community Mental Health Centers, for example, should have the responsibility for meeting the "psycho" needs of the elderly and that Area Agencies on Aging should be authorized and provided with the necessary resources to contract for, or make grants for, the psychosocial needs of the elderly.

4.(Q) Is the problem of misdiagnosis a problem of better education of psychologists, psychiatrists and social workers, nurses and physicians in geriatric mental health? If so, are the organizations you represent today not particularly well placed to help with this? And if not, just how do we deal with the problem?

(A) I agree that inadequate training of health and social services professionals and paraprofessionals continues to be a major problem. The Congress had attempted to address this issue by mandating training programs through the National Institute of Mental Health, the National Institute on Aging and the Administration on Aging. However, to date these efforts have only begun to meet the needs. There is clearly a need for increased federal support of training in aging and mental health for both professionals and paraprofessionals working in aging.

I additionally wish to note that there is also a need for increased federal support of research on Alzheimer's and similar conditions frequently misdiagnosed. The recent hearings on Alzheimer's Disease held by this Subcommittee supports the need for increased attention on this disease and other related diseases.

As evidence of organizational interest, I wish to note that these four mental health associations (American Nurses' Association, American Psychiatric Association, American Psychological Association and National Association of Social Workers) served as the co-convenors of the White House Conference on Aging Mini Conference on the Mental Health of Older Americans, and each organization is currently involved in projects related to mental health and aging. For further detail, I suggest that the Subcommittee request that each organization submit a summary statement of such activities for the record.

5. (Q) I think you stated that the groups you are representing today would like to see the Act changed to authorize the area agencies to contract and make grants to serve the social needs of the mentally ill elderly? Can't the area agencies do this now as the Act is presently written? If we wanted to do something like this wouldn't we have to require them to do it? And given that the Act, as you know probably better than anyone, has given great discretion to state and local levels, would this be a good idea?

(A) The current Act does not prohibit such activity. It does not, however, place on Area Agencies on Aging an affirmative responsibility to contract and make grants to meet social needs of the mentally ill. Furthermore, it does not provide for a specific appropriation to carry out this responsibility. As stated in my testimony, we believe that AAA's should have this responsibility spelled out in the Older Americans Act and should be provided with funds over and above their present resources to discharge this responsibility.

6. (Q) I think you stated that you would like to see the Act direct area agencies to develop working agreements with Community Mental Health Centers. Do you have any data from the survey the action group did as to how many area agencies are already doing this or as to how many Community Mental Health Centers had this sort of relationship with triple-a's?

(A) The Action Committee survey of Community Mental Health Centers focused on the delivery of mental health services to the aged, and did not question in detail the relationship between CMHCs and Area Agencies on Aging. However, members of the Action Committee did conduct eleven site visits to CMHCs and AAAs where the CMHC/AAA relationships were examined in detail. While the statistical sampling is small, the site visit findings indicate that there are some cooperative efforts between CMHCs and AAAs. Unfortunately, our site visit staff found fully coordinated efforts in only four instances. These cooperative efforts tended to occur when a staff member from one agency assumed employment in the other, and was able to maintain the working relationship.

Visits to sites in other communities revealed that the relationship between CMHCs and AAAs is less than fully cooperative, and that often there is little or no contact between the agencies. In some communities there are mutual referrals between the CMHCs and AAAs, but often the AAAs are not mental health oriented, with the contact being for consultation and education, rather than for mental health referral. It was also found that when a CMHC did not have an active program for the aged, AAAs did not refer their aged clients for mental health services.

The pattern that emerged from the site visits indicates that there is currently little incentive for coordinated effort between CMHCs and AAAs. Our proposal serves to encourage cooperation efforts by providing the necessary resources to the AAAs and develop working agreements with CMHCs and other nonprofit organizations to provide mental health services to meet the needs of the elderly.

7. (Q) You are as familiar as anyone with the Older Americans Act and the capacities of the state and area agencies on aging. Can you tell us what you think of the proposal by the National Association of Area Agencies on Aging to move more emphatically into the long-term care area, taking on in the process major case management and assessment responsibilities?

(A) I believe that Area Agencies on Aging should be able to enter into contracts, or make grants, which will result in a responsible and appropriate organization in the community being in a position to assume case management and assessment responsibilities. I do not believe that the Area Agencies should assume these responsibilities unless it can be demonstrated that there is no other organization in the community that is in a position to assume them.

I hope my remarks adequately address your concerns. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Arthur S. Flemming

/fg

Senator **Grassley**. Well, thank you. I appreciate that encouragement. And let me say that this is something that has been brought to our attention and we are going to give it the consideration that it ought to be given and I think your coming here highlights that.

I would also like to add before we go on to Dr. Carman that I am going to write the Commissioner on Aging to respond to the committee so that we may have the benefit of the administration's views on why they have not made any of those grants that you talked about in title IV. Because I think we do need that explanation and also it gives them an opportunity to make clear their rationale. But I am glad you brought it up and we will follow through on that.

Dr. **Flemming**. As a former Commissioner on Aging, I recognize that they had some fiscal problems as far as title IV is concerned.

Senator **Grassley**. Yes, and I assume that probably the answer will relate to that.

Dr. **Flemming**. That will undoubtedly be identified.

Senator **Grassley**. OK.

Dr. Carman.

Dr. **Carman**. Thank you, Mr. Chairman.

My name is Mary Carman, and I am director of the department of aging services at Prairie View, which is a private psychiatric hospital and community mental health center in central Kansas. It was founded in 1954 by the Mennonites as one of their affiliates. I am here today representing Prairie View and I am here to talk about their aging program, and I am also here as a representative of the National Council of Community Health Services.

I am aware of the time constraints and you have the written testimony, so I would like to just briefly summarize and maybe make three points.

Senator **Grassley**. Will you pull the microphone just a little closer to you.

Dr. **Carman**. Yes, sir.

First of all, I think that Dr. Flemming has very capably stated what the mental health problems of the elderly are in this society, and indeed they have been neglected by the professional mental health providers in our society.

A recent National Council of Community Mental Health Centers survey found that 59 percent of the reporting centers had aging programs; however, only 8 percent of their client caseload are elderly. I believe there are a number of problems that community mental health centers and other health professionals have in trying to address the needs of—the psychiatric needs of the elderly population. Dr. Flemming alluded to a number of them. Agism is a primary one. A secondary one is that there is a paucity of trained mental health providers that are trained to work with elderly and their families. The stigmatism of psychiatric problems in our society still remains. And a fourth but major problem is a funding problem. And these all combine, I think, to contribute to the underutilization of mental health services by the elderly.

It has been demonstrated repeatedly throughout research in the literature that we have the techniques and the ability to treat mental health problems of the elderly. It is not a matter of not being able to treat; it is the other kinds of things that pose obstacles.

Some of the handicaps that are faced by the community mental health centers are those that I have alluded to earlier and, in addition, and I can relate primarily to Kansas, but the problem has been compounded by the implementation of the block grants, the alcohol, drug abuse and mental health block grant. These changes in funding patterns, and the reduction in funds have forced the centers to reduce prevention and education programs as well as reduce overall resources available to the aging programs. Attempts to treat elderly who happen to be in a nursing home are met with further obstacles.

In Kansas, for example, the medicare initial requirements were that the person had to be brought to the mental health center. They could not be treated at the nursing home, which is contrary to much of the national policy in trying to reach the elderly person where they are.

Further problems, for example in Kansas, medicaid disallows reimbursement to a mental health professional for treatment of a person in a nursing home unless that treatment is directed toward rehabilitation which will allow that person to reenter the community. Even though that may not be an appropriate goal for a very frail elderly individual.

I would like to spend a bit of time now talking about Prairie View's program and some of the ways that we have established that. As I mentioned earlier, the aging program was established in 1977. Prairie View has a staff of about 178 individuals. The aging department has a staff of seven professional staff members, including myself as a psychologist, four social workers, a chaplain, and one mental health worker, and we have approximately 20 percent of three of our psychiatrists' time that are devoted to services to the elderly.

Diagnosis, individual psychotherapy and group therapy, as well as family therapy and psychotropic intervention where warranted, constitute the clinical core of our program. This also includes differential diagnosis between those illnesses that may be functionally caused versus caused by some organic basis or dementing illness. Patients may be seen at the center, in their own home, or in a nursing home. We have a very active consultation and education program which is aimed primarily at prevention. This includes workshops for professionals, elderly, for their families. It includes inservice training to nursing homes, to hospitals. It includes such things as psychodrama groups that we have conducted in nursing homes, life support groups in nursing homes, widows groups, assertiveness training classes for elderly, training volunteers in churches to serve as resource and crisis intervention providers to the elderly, training hospice volunteers, and so forth.

We have had a relationship with the AAA's since our inception and in fact have gotten several small grants from the different area agencies on aging. One of the problems that we as mental health centers face is that we may be responsible for a number of countries, particularly those in rural settings such as ours. The different counties intersect different AAA regions so that your staff may have to go to several, 15, even county councils on aging, and then also have to go to the regional area agency on aging. We happen to have a catchment area of three different counties, and each happens to be in a different AAA district. We have had a good relationship with the area agencies on aging and have applied for and received some grant money from them, primarily to do consultation in education. We are currently funding what we call a Focus group, a support group for family members or caretakers of elderly, as well as consultation to the county home health agency, mental health talks at senior centers, staff support groups and nursing homes and other educational events from the public.

In conclusion, I would like to say that although Prairie View and many other mental health centers have been successful in developing innovative aging programs, as well as developing linkages with the aging network, we are far from realizing our goal of providing accessible mental health services to all elderly people who are in need of these services. Again, agism, the stigma of seeking mental health services, funding problems and the lack of trained professionals continue to block the way.

In the 1981 Older Americans Act amendments, Congress included a demonstration provision to address the mental health problems of the elderly. This program has never been funded. We understand the fiscal constraints that we are all familiar with. However, the fundamental goal of the Older Americans Act is to improve the health and well-being of older Americans. Until the mental well-being of the elderly American is addressed, this goal will not be actualized. Therefore we strongly urge the committee to include language in the 1984 Older Americans Act amendments to assure that funding is made available to meet the mental health needs of the elderly Americans.

That concludes my remarks. Thank you, Mr. Chairman.

[The prepared statement of Dr. Carman and responses to questions submitted by Senator Grassley follow:]

PREPARED STATEMENT OF MARY CARMAN

Mr. Chairman and members of the Subcommittee:

My name is Mary Carman and I am Director of the Department of Aging at Prairie View, Inc., in Newton, Kansas. Prairie View, Inc., is a non-profit comprehensive psychiatric center with accreditation as a private psychiatric hospital and a community mental health center.

It has a wide range of services including inpatient, day hospital, outpatient, substance abuse treatment programs, services to aging, consultation and education, and consultation to business and industry. It was founded in 1954 and is one of 8 affiliates of Mennonite Mental Health Services. Its staff of 178 includes 5 psychiatrists, 6 Ph.D. psychologists, 16 social workers, 4 chaplains, 11 psychiatric nurses, and 31 mental health workers.

Its commitment to holistic care of people of all ages, combined with an awareness that elderly were generally underserved by mental health services, led to the establishment of an aging department in 1977.

I am also here today representing the National Council of Community Mental Health Centers which represents over 700 community mental health centers nationwide. These programs provide a wide array of community-based mental health services to persons of all ages and disability.

THE FACTS

The elderly are vulnerable to the same emotional disorders as younger adults but the prevalence of both functional and organic disorders increases with age (Pfeiffer, 1977). Various studies indicate that from 15 to 25% of older persons have significant symptoms of mental illness (Cohen, 1977). Chronic health problems, decreased income, retirement related to loss of identity, and the death of a spouse and friends are only a few of the factors which contribute to the increase in emotional problems in those over 65. The severity of this problem can be attested to by the fact that adults aged 65 and over, who comprise approximately 11% of the total population, commit 25% of the reported suicides (Miller, 1979).

In spite of the increase in depression and other psychiatric disorders in the aged, this population receives less mental health care than younger adults. According to a recent National Council of Community Mental Health Centers' survey, 59% of the reporting centers had aging programs, however, only 8% of their client case load are elderly. Agism, a paucity of mental health professionals trained to work with elderly, stigmatism of psychiatric problems in our society, and funding problems all contribute to the underutilization of mental health services by the elderly.

In recent years many of the stereotypes regarding the elderly have been challenged and more mental health professionals are willing to work with older patients. Conventional therapeutic approaches such as individual, family, and group therapies have demonstrated effectiveness with the elderly (Eisdorfer and Stotsky, 1977). Even modest therapeutic efforts go a long way toward resolving their mental health problems, enabling them to maintain a satisfactory level of functioning, and preventing further deterioration.

The 1980's and 1990's present a clear challenge to our society in terms of its treatment of its aged. Modern medicine has succeeded in preserving and prolonging life. Approximately 5,000 Americans each day reach the age of 65 while only 3,000 die -- a net gain of 1,400 elderly a day (Butler, 1977). The total number of older Americans is expected to jump from 23,000,000 today to 55,000,000 by 2030 (U.S. Census Bureau, 1977). Many of these older Americans will suffer from chronic illnesses, which will be exacerbated by emotional problems.

COMMUNITY MENTAL HEALTH CENTERS - Services to Elderly

Community mental health centers are often handicapped in their efforts to respond to the mental health needs of the elderly. Lack of trained staff, Medicare restrictions on outpatient mental health treatment, lack of funding for outreach and educational services, are all major factors that limit the community mental health center's ability to respond effectively to the aged population. This problem has been compounded in recent years since the implementation of the Alcohol, Drug Abuse and Mental Health Block Grant. These changes in funding patterns and the reductions in funds have forced centers to reduce prevention and education programs as well as reduce overall resources available to aging programs. Attempts to treat elderly in nursing homes pose even further obstacles. Medicare often refuses reimbursement unless the patient is brought to the mental health center and in Kansas, Medicaid disallows payment unless the therapy or counseling is clearly directed toward rehabilitating the patient so he/she may return to community living. The fact that that may not be an appropriate goal for a frail elderly with an emotional disorder does not matter.

Mental health centers located in rural areas have the additional burden of being responsible for large geographic distances covering 10 to 15 counties and hundreds of miles. Transporting patients to the community mental health center or center staff to the patient is often time consuming and costly.

A further difficulty for community mental health centers attempting to relate to area agencies on aging is that the CMHC's catchment areas may intersect 3 or 4 different AAA Regions. Hence, CMHC personnel must relate to numerous different local and regional councils on aging.

PRAIRIE VIEW - AGING SERVICES

As I mentioned earlier, Prairie View, Inc., established an aging department in 1977. The aging department staff currently include: 1 Ph.D. clinical psychologist, 4 social workers, 1 chaplain, and 1 mental health worker. Three of the center's 5 psychiatrists also devote approximately 20% of their time to working with the elderly. Services to the elderly and their families have shown consistent growth since the program's inception. In 1983, 72 elderly were treated as inpatients, 45 in the day hospital, and approximately 500 as outpatients (220 of these being new admissions). Diagnosis, individual psychotherapy, group therapy, family therapy, and psychotropic intervention when appropriate, constitute the clinical core of the aging department services. Patients may be seem at the center, in their own home, or in a nursing home.

A very important component of our program is differential diagnosis testing of elderly individuals to distinguish between their need for mental health services and other medical care. Psychiatric evaluations, neuropsychological testing, thorough physical assessments, and referral to specialists when indicated are all procedures commonly used at Prairie Vew to establish a correct diagnosis. This obviously involves open communication with the individual, his/her family, the attending physician, and other professionals.

At Prairie View, patients with dementing illnesses (e.g., Alzheimer's disease) are treated and not merely labeled and discarded. For example, in the early and middle stages of such an illness, the patient often benefits from individual psychotherapy aimed at reducing the anxiety and depression that usually accompany dementia. Psychotropic medication is also used when needed. In addition, family members receive counseling to reduce their stress, help them cope with the patient, and assist them in providing a stable environment for the patient. The Aging Department conducts a program called FOCUS Group (Families or Caretakers Under Stress), which meets bi-weekly with families and caretakers of elderly persons who suffer from Alzheimer's or related disorders. This program is partially funded by area agency on aging funds.

Prairie View aging department also has a strong consultation and education program aimed at prevention. Workshops are provided on a regular basis to professionals, elderly and families on issues related to aging. This also serves as a form of outreach as many elderly and their families first become acquainted with a mental health professional through these events. In addition to lessening any fears they may have regarding mental health staff, their awareness and understanding of normal aging and emotional disorders is increased.

Inservice training to nursing home and hospital staff is also provided on a regular basis. Other aging department services include: psychodrama groups in nursing homes, life support groups in nursing homes, widow's groups, assertiveness training classes for elderly, training of volunteers in churches to serve as resource and crisis intervention providers to the elderly, training nursing home staff to lead socialization groups, training hospice volunteers, and support groups for families.

RELATIONSHIP WITH AREA AGENCIES ON AGING

Networking with other agencies has been a philosophical underpinning of the aging department since its inception. However, developing linkages with AAA's is difficult because our agency must deal with several AAA's at the same time. Aging department staff regularly attend the local Council on Aging and regional Area Agency on Aging meetings. Small grants have been received since 1978 from the AAA's which have helped to support consultation and education experiences. Some of these AAA activities include: case-oriented consultation to a County Home Health organization, which is designed to help their staff more effectively work with elderly; mental health talks at senior centers; staff support groups in nursing homes; "movement to music groups" for nursing home residents with staff training; educational events for the public; inservice training to hospital and nursing home staff; and consultation to congregate housing directors and senior center staff.

CONCLUSION

Although Prairie View and many other mental health centers in this country have been successful in developing innovative aging programs, as well as developing linkages with the aging network, we are far from realizing our goal of providing accessible mental health services to all elderly people who are in need of these services. Agism, the stigma of seeking mental health services, funding problems, and the lack of trained professionals continue to block the way toward our goal.

In the 1981 Older Americans Act (O.A.A.) Amendments, Congress included a demonstration provision to address the mental health problems of the elderly. This program has never been funded. We, of course, understand the fiscal constraints that are all too familiar to all of us. However, the fundamental goal of the O.A.A. is to improve the health and well-being of older Americans. Until the mental well-being of the elderly American is addressed, this goal will not be actualized. Therefore, we strongly urge the Committee to include language in the 1984 O.A.A. amendments to assure that funding is made available to meet the mental health needs of elderly Americans.

Thank you, Mr. Chairman, for inviting us to discuss with you today the mental health needs of older Americans, and we look forward to working with the Committee on the reauthorization of the Older Americans Act.

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DR. CARMAN'S RESPONSES TO SENATOR GRASSLEY

1. Your first question asked whether or not Needs Assessments were done at the local level on a regular basis to understand the precise magnitude of the mental health needs of the elderly communities.

   A. I do not have much knowledge of the way this is done on a national level. However, I assume that it is done by many mental health centers and I am aware of several that do. In our own area, the local Area Agencies on Aging do a needs assessment on a regular basis. However, not much of their assessment is directed at emotional needs or psychiatric problems. We have not conducted a formal needs assessment at Prairie View but we are continuously assessing the need on a less formal basis. Our networking with other agencies provides us with constant feedback about the needs of the elderly in the various communities.

2. Your second question asked how Prairie View had overcome some of the obstacles faced by community mental health centers in providing services for the elderly. There are several ways we have addressed the obstacles we have encountered:

   A. Difficulty obtaining reimbursement due to Medicare regulations. The current Medicare regulations specify that Medicare will pay only $500 of outpatient psychiatric services with the recipient paying a $250 deductible. However, this stipulation can be overcome if a mental health center has a physician on site at least 40 hours a week. Under those circumstances, psychologists, social workers, and in some cases, community mental health workers can receive reimbursement under "auxiliary services of a physician." In this case Medicare will pay 80% of the outpatient services with no yearly limit. However, many community mental health centers contract for psychiatrist services on an "as needed" basis and therefore, do not meet the 40 hour a week requirement.

      In addition, we spent three years negotiating with the state and federal Medicare personnel to win the right to see elderly in nursing home settings. It has been our experience that it is often necessary and clinically advisable to provide psychiatric treatment on site in a nursing home. This allows for assessment of the individual's environment, staff, roommates, etc. However, in Kansas, the Medicare regulations stipulated that the individual who resided in the nursing home had to be seen for treatment at the mental health center. Otherwise reimbursement would not occur. Although this is an obvious discrimination against a certain segment of the elderly population, that was the stance originally taken. As I indicated, after three years of battling the Medicare officials, we at Prairie View were given written authorization to treat people in nursing homes when clinically appropriate.

B. Medicaid restrictions in Kansas have also presented some problems. For example, we continue to function under a system that denies reimbursement for individuals in nursing homes unless our goals indicate that treatment is designed to return the individual to the community. The fact that this may not be an appropriate goal for the frail elderly who has spent eight or ten years in a nursing home setting does not seem to concern the Kansas officials.

C. I indicated that lack of trained professionals who are experienced in treating elderly is often a problem faced by community mental health centers. In this regard, Prairie View has gradually and carefully built its current aging staff of seven individuals from various disciplines. We have hired only those individuals who have experience and commitment as well as outstanding clinical abilities with elderly. This has sometimes meant six months to a year of searching on a national level. In addition, from the beginning we have provided in-service training to our own staff, both inpatient and outpatient. There was some initial resistance to treating many elderly on our inpatient unit, as well as in the Day Hospital. However, continued training of our own staff, as well as their "hands on" experience of seeing many of the elderly make dramatic improvements has made most of our inpatient and Day Hospital staff not only comfortable with elderly, but truly experts in addressing their needs.

D. Agism is another problem that we have encountered everywhere. Judges, clergy, physicians, psychologists, lay people and the elderly themselves have all been influenced, to some extent, by many of the negative stereotypes attributed to the elderly in this country. We have attacked this aggressively through our consultation and education program. Since the inception of the aging department, we have conducted over 400 workshops, in-services, talks at senior centers and other forms of consultation and education. These programs have been aimed at elderly, their families, physicians, clergy, nursing home staff, mental health professionals, SRS workers, home health staff, etc. All indications are that the consultation and education programs have been effective in changing at least some of the negative attitudes toward elderly. Part of this evidence comes from the increase in referrals to our center that follows nearly every workshop or talk that we give.

3. Your third question asked whether Area Agencies on Aging can undertake appropriate mental health programs as the Act is presently written.

A. The Older Americans Act as currently written does not prohibit Area Agencies on Aging from developing mental health programs. However, there is no clear focus in the Older Americans Act with respect to establishing formal linkages between the aging network and the community mental health system. At the present time, the mental health and aging networks generally operate independently. As you know, several years ago, there was a lack of coordination between the long-term care system and the aging network. The recent interaction between these two service systems was facilitated by specific initiatives included in earlier Older Americans Act amendments. The 1984 Older Americans Act amendments provide an opportunity to establish formal linkages between the mental health and aging networks.

B. I would support the Action Committee's recommendation to amend Title III so as to direct area agencies to develop working agreements with community mental health centers (and/or private providers).

4. Your fourth question asked if the primary responsibility for the mental health of the elderly rests with the mental health system proper, rather than with the Older Americans Act network.

A. I believe that the primary responsibility for the mental health of elderly does indeed rest with the mental health system proper rather than with the Older Americans Act network. However, I believe the only way the needs can be properly addressed is with strong action and support by the Older Americans Act, as well as other government and private agencies concerned with the mental health of the elderly. Both systems need to better coordinate their activities and better understand the role that each can play in delivering mental health services to elderly Americans.

Senator **Grassley**. Thank you.

I will start with you, Dr. Carman, with a comment and question.

Our investigation tells us that your center does an outstanding job of providing services to the older people, and yet you talk in your statement about numerous obstacles that community mental health centers face in providing mental health services for the elderly.

How do we overcome some of the problems that you mention?

Dr. **Carman**. Some of it may not be under the jurisdiction of this Committee, but I believe that both the education of the general public, including the elderly and certainly of the mental health professionals, needs to happen so that we have mental health professionals that do not buy into the agism that is prevalent in our society.

I think the funding mechanisms have to be looked at in order to allow community mental health centers or other private agencies to address mental health needs of the elderly; that the rules are simply so restrictive that some of of medicare reimbursements, for example, and/or the medicaid that it makes it very difficult, if not impossible.

Senator **Grassley**. So that the single—the response centers around then the single one of funding mechanisms?

Dr. **Carman**. I see that as being the primary one. The others, as I mentioned, are also part of it.

Senator **Grassley**. OK.

Dr. Flemming, besides speaking for the coalition, you also are involved in speaking for four very important associations whose members are involved with providing mental health care to older people.

Can you tell us what priority the four associations have placed on mental health services for older people, and particularly on their chronic mental health needs?

Dr. **Flemming**. Well, I am encouraged by the fact that at least four of these professional organizations served as cosponsors of many White House Conferences on Aging preceding the 1981 White House Conference on Aging. I regard that as a very real breakthrough because it indicated that some of the professionals in the field were beginning to pay attention to this problem of the mental health care of the older person. My understanding is that the organizations, each one of them do have some special programs, and my suggestion would be if the committee and staff could address a communication to each one of them and ask them to detail those programs, I think it would be a very important addition to the record. But the fact that they are participating in activities of this Action Committee, which they do from time to time, including the presentation of this testimony, the fact that they are getting started in this particular area, I think indicates that we are beginning to get a breakthrough on the agism which has been prevalent in the professional organizations, because in our hearings, the Civil Rights Commission hearings on this issue, we had some of the leaders, community mental health clinics before us as witnesses, and we pressed them and say why is it that you are always, the total number of people that you are serving, only 3 to 4 percent are older persons? Well, the first response we get would be they do not come to us. My response was, well, of course, they are not going to come to you. What kind of an outreach program do you have? Well, they did not think that was really a part of their responsibility to run an outreach program. Then they would say we do not have any money for it anyway. We kept pressing several times and would get the response, well, we have limited resources and we think it is a better investment of those resources to focus on children, young people, middle-aged people than the older persons.

I remember responding to one I get your message, you figure that we are not going to be around very long so why worry about us, as far as mental health. That was a clear manifestation of agism. In other words, they were deliberately discriminating against the older persons on that ground, and that is a real issue that we have to confront. And I agree that it is tied in with the educational issue because this agism manifests itself because oftentimes the professional has not been trained to deal with the issues of older persons and, consequently, like all other human beings, the professional who has not been trained will try to avoid displaying her or his ignorance and consequently they do everything they can to avoid dealing with older persons. That is not only true of people in the mental health area, that is true of physicians, it is true of ministers, agism is prevalent in our religious institutions for the same reason.

Senator **Grassley**. My last question will be to you, Dr. Flemming, and I ask you this about how Older Americans Act is presently written and structured. Is there anything in it to prevent the aging network from concerning itself with the mental health needs of older people?

Dr. **Flemming**. No, there is not anything in it that would prevent them from taking the initiative. However, my feeling is that the Congress could render a very real service by categorizing this particular area. I know some people differ with me on this, but I believe that when an area has been neglected by our society, generally that the Congress, the Federal Government can render a very real service by identifying that area of neglect and saying we expect you to do something about it, and we are providing you with some money to do something about it. So it is not just an authorization but it becomes a direction, and I do not think we are going to get a breakthrough over the country as a whole unless that is done.

Senator **Grassley**. Do either one of you have any last point that you want to make before I call the next panel?

OK. I thank you very much for your participation.

Dr. **Flemming**. Thank you.

Senator **Grassley**. OK.

I would like to introduce now panel 5. Mr. Peter Meek will be the first witness for our last panel, and then Dr. Russell Mills and Dr. Eric Pfeiffer. They direct long-term care gerontology centers, Dr. Mills in Kansas and Dr. Pfeiffer in Florida. This subcommittee is very interested in long-term care centers because we think it has great potential to help our long-term care problems. I am particularly intrigued by the prospect that these centers could help our State and area agencies on aging through providing technical assistance in education. Dr. Paul Kerschner will be speaking today for the American Association of Retired Persons, the largest organization representing older people in the country. He is going to tell us about the major project in health screening and the health education that the AARP is going to start this spring.

I would like to—I have introduced four people. You are a staff person? OK. Would you give us your name for the record.

Dr. **Kerschner**. Her name is Meredith Cody.

Senator **Grassley**. With AARP as well?

Dr. **Kerschner**. Right.

Senator **Grassley**. I would really urge you, because of an appointment that I have, to summarize in 5 minutes, and the reason for that is because I think a Senator should be present to receive all testimony. And when the red light comes up is when the 5 minutes are up.

Would you proceed.

STATEMENTS OF PETER G. MEEK, VICE PRESIDENT, NATIONAL HOMECARING COUNCIL, INC.; DR. RUSSELL MILLS, DIRECTOR, UNIVERSITY OF KANSAS LONG-TERM CARE GERONTOLOGY CENTER; DR. ERIC PFEIFFER, DIRECTOR, UNIVERSITY OF SOUTH FLORIDA LONG-TERM CARE GERONTOLOGY CENTER; AND DR. PAUL KERSCHNER, ASSOCIATE DIRECTOR FOR LEGISLATION, RESEARCH AND DEVELOPMENTAL SERVICES, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. **Meek**. Yes, Mr. Chairman. I think my presentation is brief enough so that I will beat that 5 minutes.

The National Home Caring Council, a national nonprofit, standard setting, accrediting organization, promoting quality homemaker-home health aid services, is pleased to present our views to your subcommittee concerning home care services and long-term care as it relates to your consideration of the Older Americans Act.

At this point, I would also like to commend you and your subcommittee members, as well as your subcommittee staff, for its swift and dedicated efforts to examine, improve and reauthorize this important historical public law.

Provisions in title III of the Older Americans Act direct State and area agencies on Aging to develop and maintain comprehensive and coordinated long-term care delivery programs designed to maintain elderly individuals in their homes through planning, coordination, program development and advocacy. A major component of the total long-term maintenance and coordination program is the availability and delivery of quality homemaker-home health aid services. We believe the targeting provisions of the Older Americans Act related to home care services are sufficient as they now stand. They make possible a range of activities and services needed by older-Americans, regardless of social or economic background, yet allow for special emphasis on the socially and economically deprived.

As we become a nation of older Americans, we are affixed to a wide range of social and economic situations. I believe it is important to point that out, while it may not be possible to be more specific legislatively, it may be advisable to make specific recommendations, regarding special protective treatment and consideration of some elderly individuals, in the committee report. In the near future, as the percentage of the old old—1985 years and older—dramatically increases, it will be necessary to make special considerations for these persons. Thus services should be rendered to everybody who needs them, but with a special emphasis on those who need them most.

A major area of concern to the National HomeCaring Council is our firm belief that the Administration on Aging needs to be charged with the responsibility of requiring national standards for participation in the home care initiatives set forth by the Older Americans Act. Currently, there are practically no provisions at the Federal, State or local levels to support and maintain the integrity of home care services. The recent and continuing proliferation of home care services virtually begs for a precedent to be set in this area. We believe that it is vital to require that in-home care agencies participating in funding through the Older Americans Act be accredited by a responsible national organization, such as, for example, the National HomeCaring Council, and further that the Department of Health and Human Services' "Model Curriculum and Teaching Guide for the Instruction of the homemaker-home health aide" be recognized as the basic text for the training of homemaker-home health aides. The Public Health Service has made references in the Federal Register to this guide in its announcements for training and grant moneys for home care. This policy could easily be adopted by the Administration on Aging.

We would also like to address a situation that could pose serious issues for the administration of the Older Americans Act. This is the designation of individuals providing homemaker and chore services under the OAA as independent contractors. We raise the issue to inform the members of this committee of a potential problem, and we hope that any change to the OAA during its reauthorization would build in safeguards to protect against potential abuses of the independent contractor status.

The National HomeCaring Council would like to offer its assistance and expertise in developing these sorely needed initiatives. We are prepared to work with this committee and the Congress as you consider improvements to a very important Federal commitment.

Thank you for this opportunity.

[Responses of Dr. Meek to questions submitted by Senator Grassley follow:]

QUESTIONS FOR MR. PETER MEEK FROM SENATOR CHARLES E. GRASSLEY

1. You recommend in your statement that the Administration on Aging arrange for accreditation by your organization for home care agencies participating in Title III programs and that AOA accept your organization's model curriculum as a basic training text for homemakers.

This Committee can certainly ask the Commissioner to report to us on the question of how quality is assured in these Older Americans Act programs.

You made essentially the same request, if I understand it correctly, to the Health Care Financing Administration last year. How do matters now stand with that request?

2. Approximately how many home health or homemaker-home health agencies exist across the country? And how many of these agencies are accredited by the HomeCaring Council? To what extent are home care agencies which receive Medicaid, Medicare or Title XX funds accredited by the HomeCaring Council?

3. Can you describe the HomeCaring Council's accreditation process? How does your accreditation process differ from the process used for certification of Medicare and Medicaid providers?

4. Is accreditation by a national organization such as your own a sufficient guarantee of service quality in home care services, or do we need to arrange for routine checks by a capable agency at the local level?

5. In your statement, you referred to the potential of an independent contractor problem in administration of Title III home care activities. Can you tell us a bit more about what this problem is, and what we might do more precisely to ensure that this does not become a problem in Older Americans Act programs?

RESPONSES FROM MR. MEEK TO SENATOR CHARLES E. GRASSLEY

1. We are urging that, either in legislation or in the supporting regulations, there be an expressed commitment for AOA to take some responsibility for the quality of all home care services it is funding through Title III. This commitment would be expressed in assigning responsibility to AOA for assuring that standards of quality are met and citing such devices as our accreditation program for homemaker-home health aide services (which is based, in fact, on the definitive quality standards for the field that the Council has developed and refined over the years). Endorsement or citation of our standards would include the use of the Model Curriculum since the standards we have set include provision of services by homemaker-home health aides trained in accordance with the Model Curriculum.

   In urging this commitment on the part of AOA we are not necessarily urging a costly addition to the Title III program. Data show that agencies using trained homemaker-home health aides and providing good supervision have lower case costs. Using an existing mechanism such as the accreditation program of the National HomeCaring Council would be cost-effective since it is already in place.

With the Health Care Financing Administration the National HomeCaring Council has gone further than suggested above to the Administration on

Aging and has requested recognition of its accreditation program by the Health Care Financing Administration (HCFA) through the awarding of deemed or subdeemed status. Dr. Carolyn Davis wrote in August 1983, in response to our request that,

> I fully anticipate that the integration of private and Federal sector goals and responsibilities will continue to strengthen the health delivery system, and I encourage NHCC to remain an active participant in this important process.

A meeting with HCFA officials in December was less encouraging. They informed us that there were a number of applications for deemed status ahead of ours, and that in any case the policy of "deeming" that agencies which have met the standards of specific voluntary accrediting bodies have met the conditions for participation in Medicare was not being extended at this time. In short, the awarding of "deemed status" appears to be "on hold," despite the statements by this Administration of wishing to make maximum use of the nongovernmental sector.

We also asked the Health Care Financing Administration for recognition of the Model Curriculum, which was developed under a sole source grant to the National Council from the Public Health Service. Originally published by the Superintendent of Documents, it is currently available through the National HomeCaring Council. Dr. Davis wrote:

> Revised home health aide training requirements are currently under development in HCFA. When these requirements are promulgated as final rules it will be possible to evaluate them against your Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide to determine whether the standards and the outcome of their use are comparable.

The Model Curriculum has been cited twice in the Federal Register by the Health Resources and Services Administration for grant programs.

Feasibility of Recognition by the Administration on Aging

Since the Administration on Aging has no formal conditions for an agency's participation in its funding of homemaker-home health aide services and no formal process like that of awarding deemed status, the Administration might be freer than the Health Care Financing Administration to give recognition to the accreditation/approval by the National HomeCaring Council. A simple phrase like, "Where possible contracts are to be awarded to homemaker-home health aide services accredited by the National HomeCaring Council," or "Priority in awarding contracts is to be given to services which have documented conformity to the basic national standards through accreditation or approval by the National HomeCaring Council" would accomplish a great deal in securing the quality of service paid for by the Administration.

Commitment to quality care through the Accreditation Program of the National HomeCaring Council and, in turn through the Model Curriculum, would mean obligating state and area agencies to bring their programs into conformity with the basic national standards, including the training of their aides. Consumers would be protected in ways they are not now protected, and the Administration on Aging would not have to set up a new and costly monitoring process to accomplish this.

2. The National HomeCaring Council estimates there are from 6,000 to 8,000 agencies in the United States providing homemaker-home health aide-type services.

Of these agencies, 140 have homemaker-home health aide services which are accredited or approved by the National HomeCaring Council. (Approval involves a desk review of the self-study without a site visit.) A representative of a large proprietary chain employing homemaker-home health aides participated on our Standards Committee. She was an excellent member who made clear, sensible suggestions. When we asked why the agencies in her chain did not apply for accreditation, she said, "There is no demand for it. Until accreditation is required, agencies will not apply for it." This situation was exactly the experience with the accreditation of hospitals when Titles XVIII and XIX were added to the Social Security Act.

I believe it would be safe to say that every agency the National Council accredits receives Medicaid, Medicare, and/or Title XX funds. Regrettably, the percentage of agencies receiving those funds which are accredited by the National Council is small.

3. The National Council's accreditation process is carefully constructed using standards set by a committee of administrators and volunteers in the homemaker-home health aide field. The standards are subsequently revised based on experience with their use.

Documents Supporting Standards

The standards are operationally defined through a document titled, Interpretation of Standards, which is in turn enlarged for applicant agencies into a self-study manual, which, in addition to stating the Interpretation, details documentation needed to demonstrate conformity with the standards. The self-study is largely precoded so that agencies do not waste time providing long essay responses, and so that the National Council's peer reviewers can review the self-study in an organized, efficient way.

The Review Process

Each self-study submitted by an agency is reviewed by two peers prior to a site visit. The final report is reviewed by the Accreditation Commission, which determines the disposition of the application. The Accreditation Commission is made up of 12 - 15 experienced administrators and representatives of the field from all over the United States

Difference Between National HomeCaring Council Accreditation and Certification for Medicare/Medicaid

The Medicare and Medicaid certification processes are carried out by state surveyors and differ state by state. A national organization such as the Council can profit by experience with all the states it serves and provide a predictability and uniformity in process which the state surveys tend not to do. Moreover, trained peer reviewers using standard instruments which must be reviewed before the site visit can focus during the site visit on information which gives an in-depth picture of vital elements of conformity to standards in the agency. They need not waste time obtaining basic data during the site visit on such matters as personnel policies and bylaws.

Enclosure: The Standards.

4. Accreditation by a national organization is an accepted way to monitor the quality of services. Experience with the Joint Commission on Accreditation of Hospitals and with organizations which accredit educational institutions has shown that national accreditation programs can operate effectively on a broad scale without additional monitoring by local agencies.

5. An independent contractor is a self-employed worker, a person who sells his or her services to an agency or an individual. A physician or a nurse or an architect may be an independent contractor, sending in quarterly tax payments to IRS and arranging for his or her own malpractice and health insurance and retirement plan. A homemaker-home health aide works with people who are frail and/or seriously ill or disabled and who may be harmed seriously through the ignorance or abuse of a person who is not properly selected for the job, trained and supervised. Many agencies receiving public money act as registries, sending out untrained or poorly trained aides. Yet the aides are expected to serve people whose situations are complex, which have not received an in-home assessment and are not being supervised. Sometimes the aides do not show up; sometimes they send in friends as substitutes when they need the day off. The National Council has on file many instances of neglect and abuse through the use of aides left on their own with extremely vulnerable individuals. Paraprofessionals working with ill or disabled people should work for an agency which is accountable for their performance, which sends a professional in the home periodically to check on the aide's performance and the patient's condition, and which is immediately available by telephone to the aide and the patient and family to handle crises.

An agency which takes funds to care for elderly people but essentially acts as a registry exploits the patient, the taxpayer, and the aide herself. These workers, who usually make little over the minimum wage, and in some states not even that, do not have the money and often do not have the sophistication to pay Social Security, insurance, and so forth. Unemployment or illness may put them on welfare, so the taxpayer is not likely to save through their having been used as independent providers.

The Older Americans Act regulations should require that funds go only to provider agencies which employ the homemaker-home health aides and are accountable for the service they provide.

Basic National Standards for Homemaker-Home Health Aide Services

STRUCTURE

Standard I.	There shall be legal authorization to operate the agency.
Standard II.	There shall be a duly constituted authority and a governance structure for assuring responsibility and for requiring accountability for performance.
Standard III.	There shall be compliance with all legislation relating to prohibition of discriminatory practices.
Standard IV.	There shall be responsible fiscal management.

STAFFING

Standard V.	There shall be responsible personnel management including: A. Appropriate processes used in the recruitment, selection, retention, and termination of homemaker-home health aides; B. Written personnel policies, job descriptions, and a wage scale established for each job category.
Standard VI.	There shall be training provided to every homemaker-home health aide for all service to be performed.

SERVICE

Standard VII.	There shall be written eligibility criteria for service and procedures for referral to other resources.
Standard VIII.	There shall be two essential components of the service provided to every individual and/or family served: A. Service of a supervised homemaker-home health aide; B. Service of professional persons responsible for case management functions.

COMMUNITY

Standard IX.	There shall be an active role assumed by the service in an ongoing assessment of community health and welfare needs and in planning to meet these needs.
Standard X.	There shall be ongoing interpretation of the service to the community.
Standard XI.	There shall be evaluation of all aspects of the service.

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Senator GRASSLEY. Thank you, Mr. Meek.

Dr. MILLS.

Dr. MILLS. Thank you. I appreciate the opportunity to be here today. I appear as president of the Association of Long-Term Care Gerontology Centers, which is a mouthful, and I am director of the University of Kansas Center. There are now 11 such centers spread around the country with at least one in each of the 10 HHS regions.

We think that the development of community-based long-term care systems such as we have been talking about here today is an extremely high priority. You have heard a lot about what the system should accomplish, and I will not repeat any of it.

We are, however, convinced that the aging network, specifically the AAA's, can play a major and often vital role in these developments in their own areas. The roles will differ drastically depending upon their capabilities and what already exists in their communities. You, Senator Grassley, already said that the AAA's vary widely in their capabilities and their present involvement in such efforts.

Although I represent the Association of Long Term Care Gerontology Centers, my own experience is essentially in rural areas—Iowa, Kansas, Missouri, and Nebraska—where the proportion of elderly is high and growing rapidly, and where most of the AAA's are small and are just getting involved, if at all, in the development of long-term care systems. And yet they are often the only act in town capable of generating cooperative programs. Often they are not, but often they are.

But Dr. Pfeiffer, who will speak next, has a different perspective on the environment, and you will hear from him as to what he is doing.

A major thrust of the centers is facilitation of the development of comprehensive and coordinated community-based long-term care systems and services.

The tasks involved are major and complex. Those to which the long-term care centers address themselves include: First, developing the required knowledge base for an effective system. Much remains to be done, especially in the area of policy relevant information, as was already mentioned today.

Second, educate and train the large numbers of various types of personnel needed to develop and operate the systems, and increase the competence of existing providers by extensive continuing education and training programs, including attitudinal aspects of such training.

Third, expedite the rapid and effective utilization of newly developed knowledge.

The expansion of the knowledge base involves research programs on the many facets of long-term care, as well as development of experimental and demonstration service models which can be tested and evaluated for effectiveness, cost, fiscal impact, and long-range impact on outcome for the clients. A major part of this effort, of course, is development of policy relevant information.

Expediting the application and utilization of newly developed knowledge is the most important interface which we have and should have between the centers and the aging network. This requires close working relationships in providing technical assistance; the centers often work one-on-one with aging organization staff in the development of operational programs. The centers provide workshops and training programs for networks and other provider staff; they publish newsletters and informational bulletins, provide bibliographies and resource materials. Most important, they work one-on-one with Area Agencies and other providers who request such assistance.

Service model and research projects that are an important part of the center activities address the various phases of development of community-based care, such as assessment, case management, linkage of hospital-based geriatric evaluation teams with community-based service agencies, and effective utilization and support of the informal support network. Some of the experimental projects which are being carefully evaluated include one which organized intergenerational neighborhood networks to provide the needed service to older residents and others which provide support systems for families of Alzheimer's victims.

There are now operational 175 different technical assistance projects which involve State Units on Aging, Area Agencies on Aging, nursing homes, housing facilities, other kinds of activities in providing support services for the elderly. There are significant and continuing working relationships clearly identified between the centers and 40 different Area Agencies on Aging. That is less than 10 percent of the Area Agencies in the country, and yet developing those working relationships is a time-consuming and often difficult task, and responding to requests for help for the limited number of centers is often difficult. The working relationships range from developing information on which to base policy decisions to implementation of community-based service and case management systems, to development of microcomputer-based management and client tracking systems.

Specifically, I can speak in more detail in what we are doing in the Kansas center. We have been working directly with 5 of the 11 Area Agencies in Kansas and with 2 in Nebraska in planning and developing community-based assessment and case management systems. The process has included general public information sessions to develop public support for the development of the systems, staff training, continued participation in the development process, provision of assessment and care planning instruments and procedures, et cetera, et cetera, et cetera.

In addition, our center is working with two of the Area Agencies and the State unit in Kansas, with the two Area Agencies in Nebraska, and with one AAA in Iowa in the implementation of microcomputer-based management and service recording systems.

In short, the long-term care gerontology center provides a major and unique resource in the efforts to develop a rational policy for long-term care of the frail elderly, and for the development of effective community-based service systems. It is a resource that facilitates, educates, and develops new knowledge. It is not meant to be a major direct provider of services in the sense that the aging network itself is, which clearly has primary responsibility nationwide for operation of the service systems.

Thank you.

[The prepared statement of Mr. Mills and responses to questions submitted by Senator Grassley follow:]

ASSOCIATION OF LONG TERM CARE GERONTOLOGY CENTERS
January 31, 1984

I appreciate the opportunity to participate in this hearing on "Long-Term Care Under the Older Americans Act", under the auspices of the Senate Subcommittee on Aging.

I am Russell Mills, Director of the University of Kansas Long Term Care Gerontology Center, and President of the Association of Long Term Care Gerontology Centers. Eleven such Centers, initiated and funded by the Administration on Aging, are now operational, with at least one in each of the 10 HHS Regions of the country. With me is Dr. Eric Pfeiffer, Director of the Suncoast Long Term Care Gerontology Center, at the University of South Florida. He is Past President of the Association.

The Long Term Care Gerontology Center Program was established as another major resource for improvement of the long term care of the vulnerable or frail elderly, using the term"long term care" in its broad sense. The Center Program focuses the many varied and multidisciplinary resources of major universities, including their medical and nursing schools, in a multi-faceted approach to the problem.

The major thrust of the Centers is to facilitate the development of comprehensive and coordinated community-based Long Term Care Systems and Services for vulnerable older persons. These systems and services require not only traditional health care but also social services and maintenance support. They require the participation of many disciplines, including physicians, nurses, social workers, allied health personnel, administrators, gerontologists, and others; they require the effective meshing of medical and other services. The systems must have the organizational structure and operational capability to target care to individuals truly at risk of institutionalization or clearly on a course leading to institutionalization without appropriate intervention. They must also strengthen and use informal supports, to preclude or minimize the necessity of providing formal care. They must incorporate flexibility, client choice, and attention to appropriate selection of residential setting as integral parts.

Multidisciplinary assessment and comprehensive case management are key components of effective systems with the characteristics described above.

The tasks involved are major and complex; those to which the Long Term Care Centers address themselves include:

1. Develop the required knowledge base for an effective system; much remains to be done.
2. Educate and train the large numbers of various types of personnel needed to develop and operate the systems, and, equally as important, increase the competence of existing providers by extensive continuing education and training programs.
3. Expedite the rapid and effective utilization of newly developed knowledge.

The Long Term Care Gerontology Centers, based in and with access to the many resources of the universities, are particularly suited to these tasks. In doing them they are, and will be even more so, a major resource to the Aging Network and other providers, which have the nationwide operational responsibilities for implementation of the required systems and services.

Expansion of the knowledge base involves research programs on the many facets of long term care, as well as development of experimental and demonstration service models which can be tested and evaluated for effectiveness, cost, fiscal impact, and long range impact on outcome for the clients. The Centers are all deeply involved in such research, and in such service models.

Education and training are primary functions of universities; the multidisciplinary Long Term Care Gerontology Centers all have direct access to the top levels of their university organizations, and can call on the educational resources of the entire university. Equally as important is the availability of the service models as sites for practical experience for the students and trainees; practical exposure to such environments, with their interdisciplinary approaches and involvement in generation of the knowledge and experience base, is the best possible preparation for good practice. All of the universities with which the Centers are associated have extensive and effective continuing education (CE) programs serving broad geographic areas; these CE resources are already widely used by the Centers in reaching practicing professionals and other service personnel.

Expediting the application and utilization of newly developed knowledge - a major activity of all the LTCGCs - is the most important interface between the Centers and the Aging Network. The Centers provide technical assistance to the Network, making available the up-to-date information and resources present in the Centers, and working one-on-one with Aging organization staff in the development of operational programs. The LTCGCs provide workshops and training programs for network and other provider staff; they publish newsletters describing the latest information and procedures; they provide bibliographies and resource materials. To assure rapid availability of new knowledge among the various LTCGCs they have established a computerized Intercenter Information System, with regular and systematic exchange of information about what all the Centers are doing and what they have developed which could be useful to the Network. This information is now available through the Regional HHS Offices to State Units on Aging and to the Area Agencies on Aging. Extensive public information/information dissemination programs are also carried out by all the Centers.

All these types of activities are mandated by the LTCGC Program guidelines and by the terms of the grants partially supporting the Centers - Research, Service Model Development, Education and Training, Technical Assistance, and Information Dissemination. All are interrelated and mutually supportive.

To illustrate these activities some specific figures and examples are given here.

In December, 1983, the 10 operational Centers then reporting to the Information System, had a total of 587 active projects under way - 84 Service Model, 104 Research, 146 Technical Assistance, 158 Education and Training, and 95 Information Dissemination. About half of these were started during 1983, as others were completed and phased out.

Most of the Service Model and Research projects involved students in their activities; medicine, nursing, social work, gerontology, sociology, psychology and public administration students were most frequently cited.

A total of 1414 professional staff associated with the LTCGC programs were listed as involved in the Service Model and Research projects. They included 318 physicians, 250 nurses, and 177 social workers, as well as smaller numbers of psychologists, sociologists, gerontologists, public administrators, urban planners, specialists in public health, epidemiologists, educators, business and management faculty, audiologists and speech pathologists, and others.

Typical Service Model and Research projects at several of the Centers address the various phases of development of community-based care, such as assessment and case management as core elements of the system, linkage of hospital-based geriatric evaluation teams with community-based service agencies, effective utilization and support of the informal support network for families, frail elderly, and caregivers, etc. Experimental projects which are being carefully evaluated include one which organized intergenerational neighborhood networks to provide needed services to older residents, as well as other projects which provide support systems for families of Alzheimer's victims.

LTCGC staff taught in 165 courses in aging/long term care, with 6,310 students enrolled. The enrollments included 3459 students of medicine, 1,076 nursing students, 534 social work students, as well as students from most of the other disciplines mentioned above. Almost all the courses were interdisciplinary in content; over 900 of the students enrolled in didactic courses were enrolled along with students of other disciplines. One-fourth of the total enrollments were in clinical/practical experiences.

The LTCGCs had primary responsibility for 160 continuing education and training workshops and courses for practicing professionals and other workers. The attendees included 2556 nurses, 1033 physicians, 1329 social workers, 433 aides of various kinds, 812 administrators, 238 Aging Network staff, 1043 provider and service staff, 205 allied health personnel, and 352 volunteers and public. Total LTCGC staff time devoted to these educational efforts (and reported) was 13,424 hours.

There were 175 technical assistance projects reported in which the types of recipient organizations were listed; multiple recipient organizations were often listed for a given project. Among the recipients were listed 134 nursing homes, 113 congregate housing facilities, 102 aging/community service organizations (not AAAs), 86 hospitals, 80 home care agencies, 76 other government agencies, 43 adult day care facilities, 35 community-based senior centers, and 23 legislative bodies.

Significant and continuing working technical assistance relationships are identifiable in the Information System between LTCGCs and 40 different Area Agencies on Aging, 5 Associations of AAAs, and 42 State Units on Aging. These working relationships range from developing information and positions on which to base policy decisions, to implementation of community-based service and case-management systems, to development of microcomputer-based management and client tracking systems.

Obviously the large number of AAAs has so far made it impossible for the few LTCGCs to have direct contact with most of the AAAs; procedures are now being developed to work with groups of AAAs on joint projects, particularly outside the major urban areas, and to work with Associations of AAAs.

To give specific examples of which I have first-hand knowledge, the University of Kansas LTCGC has been working directly with the Kansas Association of AAAs, and with 5 of the 11 AAAs in Kansas and with 2 in Nebraska, in the process of planning and developing community-based assessment/case management systems. The process has included public information sessions in the communities, staff training, and continued participation in the development process. In addition, the LTCGC is working with 2 of the AAAs and the SUA in Kansas, with the 2 AAAs in Nebraska, and with one AAA in Iowa in the implementation of microcomputer-based management, client tracking, and service reporting systems, utilizing the expertise the LTCGC has developed during implementation and operation of the LTCGC Intercenter Information System.

In short, the Long Term Care Gerontology Center Program provides a major resource in the efforts to develop a rational policy for long term care of the frail elderly, and for the development of effective community-based service systems. It is a resource that facilitates, educates, and develops new knowledge -it is not meant to be a major direct provider of services nor to be a competitor of the Aging Network.

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QUESTIONS FOR DR. RUSSELL MILLS FROM SENATOR CHARLES E. GRASSLEY

1. According to the briefing materials the Administration on Aging has made available to the Committee, and as Dr. Mills pointed out in his testimony, the long-term care gerontology centers have several major responsibilities.

What priority is attached to the regional resource role of the centers among these several responsibilities? And do you have any quantitative indicators of this priority?

2. The responsibility to be a resource on a regional basis includes not only state and area agencies on aging but also other state and local actors in the long-term care area.

Just within this regional resource responsibility, can you tell us what priority is attached to the state and area agencies on aging as contrasted with other state and local actors? And do you have any quantitative indicators of this priority?

3. According to the briefing materials we have, the centers have been involved in long-term care system development. I believe that it is the case that, as part of this activity, some centers have been involved in development of case management activities.

From your experience in the system development area, do you have any response to the proposal of the National Association of Area Agencies on Aging about the triple-a's long-term care activities? More specifically:

Would you agree that the triple-a's should be the major local area management organization for long-term care? And should the triple-a's move more emphatically in the direction of providing formal case management services?

4. What is the purpose of the Association of Long-Term Care Gerontology Centers?

5. Can you elaborate on some of the difficulties encountered in trying to work with a large number of triple-a's with differing levels of involvement in long-term care activities?

THE UNIVERSITY OF KANSAS
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February 20, 1984

Senator Charles E. Grassley, Chairman
Senate Subcommittee on Aging
Hart Senate Office Building, Room 404
2nd & Constitution, N.E.
Washington, D.C. 20510

Dear Senator Grassley:

I appreciated the opportunity to testify before the Sub-Committee on Aging, on behalf of the Association of Long Term Care Gerontology Centers.

My answers to your additional questions are listed below:

1. The regional resource role of the Long Term Care Gerontology Centers is at least as important as any of the other major responsibilities of the Centers. Since it is a relatively new and rapidly developing role, it is receiving the most concentrated attention in all the Centers. Quantitative indicators are difficult to obtain. However, as I indicated in my testimony, the Centers each have ongoing technical assistance relationships with an average of four Area Agencies on Aging as well as with a number of other organizations. Conservatively 20-30% of our paid staff time is devoted to such activities.

2. Within this regional resource responsibility the State and Area Agencies on Aging clearly have top priority, as contrasted with other state and local actors. Quantitative indicators of this priority include memberships on the Advisory Boards of the Centers, and the numbers of technical assistance projects cited above. Area Agency and State Unit on Aging Directors are on all the Advisory Boards - the only such universal representation. In our case they make up about 20% of the membership.

3. We believe strongly that the triple-A's should move more emphatically in the direction of providing formal case management services. As I said at the hearing, the triple-A's blanket the country; they have already established linkages with other agencies

Main Campus, Lawrence
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and local governments; and they very often are in the best position to provide the leadership needed. In addition, they usually are not direct providers in competition for service dollars. In many communities, therefore, it is appropriate for them to be the major local area management organization for long-term care. We believe that their role should be strengthened and resources provided for them to take that role. If in certain locations and situations, already well organized, it is not practicable to assign them the major role, they should certainly always be a major participant and contributor.

Rosalie Kane made a number of statements at the hearing supporting the role of AAA's in this endeavor. We agree with her. She emphasized that the Aging Network already has a commitment to community-based long term care. This thrust represents a logical evolution in the direction that the AAA's are already moving. It recognizes that functionally impaired elderly, regardless of income, are in the group most in need of advocacy, service coordination, and help from an agency that by statute is dedicated to the well-being of the elderly.

Incidentally, all the Centers are involved in long term care system development activities at various levels - state and local. We, for instance, already play a major role at the state level in Kansas, and are working regularly with 7 triple-A's in this region in system development.

4. The purpose of the Association of Long Term Care Gerontology Centers is to expedite communication, sharing of resources, and cooperative activities among the Centers. Through this organization the Centers build on each other's expertise, so as to provide a multiplier effect on their efforts, and so as to avoid unnecessary overlap and duplication of effort. The Association also provides general information about Center activities, and promotes system development in long term care.

   The Centers, we believe, collectively represent a unique body of knowledge and expertise on issues and approaches in the area of long term care system development.

5. Some of the difficulties in trying to work with a large number of triple-A's which have differing levels of involvement in long term care activities relate to the fact that it is difficult to group together triple-A's with similar concerns and technical assistance needs. We're working towards such groupings to ensure that our time and efforts have the maximum possible impact.

Please let me know if you need further information.

Sincerely,

Russell Mills

Russell C. Mills, Ph.D.
President, Association of
Long Term Care Gerontology Centers

RCM/drr

Senator **Grassley**. Thank you, Dr. Mills.

Dr. Pfeiffer.

Dr. **Pfeiffer**. Thank you, Senator Grassley.

I would like to go back to ground zero and start with the definition of long-term care. It is a somewhat complex definition, but H.L. Mencken said that every complex problem had a simple solution and that simple solution was always wrong.

Long-term care is the entire system of health and social service programs that are required by older persons who, as a result of either physical or chronic mental disorder, have lost their ability for self-care or for living independently. It no longer just includes nursing home beds; it includes ambulatory care, day care, board and care facilities, life-care facilities, and nursing homes as well. But it also includes the acute-care-system, which is incident to long-term care programs.

Long-term care has now become a national priority for only one reason, and that is money. I used to say that there were many reasons, including demographic factors and human factors, which influenced us to move into a priority area. But the real reason why long-term care is riveting our attention now is that it is now and it is going to be more so later a budgetbuster to both Federal and State budgets in the area of human services. We have to be concerned.

The rate of increase of expenditures for nursing home care has been phenomenal, rising from $7 billion in 1973 to $18 billion in 1979, and it is expected to rise conservatively estimated to $79 billion, more recently estimated, I think, to $90 billion by the year 1990. That is only 6 years away.

The magnitude of the long-term care problem requires that we prepare for the gathering tidal wave of disabled elderly in need of care in a systematic and comprehensive way.

This is not such a farfetched idea. In fact, there is precedent for it. This country, at one other point in the major population shift during the period of the baby boom, prepared for the coming wave of children. The tidal wave of elderly persons clearly is visible on the horizon and demands that we do likewise.

Accordingly, we need to implement a plan that meets certain criteria. It does not mean building more nursing homes. It means implementing a community-based program to train personnel to provide service to the elderly, whether by professionals or by family members. That plan could not afford waste of human or fiscal resources. It cannot afford to be haphazard or piecemeal. It must mobilize all the diverse resources of government, private enterprise, and the academic community.

The Long-Term Care Gerontology Centers Program of the Administration on Aging was in fact designed to assist in developing this plan. Since 1980, in fact, a network of such long-term care centers has been established in various parts of the country in each region, in Rhode Island, in New York, Pennsylvania, Florida, Wisconsin, Kansas, Texas, Utah, and Arizona, California, and the State of Washington. These centers are all based in major universities, but they interact extensively with community providers and with State Units on Aging and with Area Agencies on Aging. Each of them constitutes a major resource for its own region, but together they constitute a national resource on long-term care.

The centers are unique in the sense that they do nothing but long-term care. Like the ad for Kentucky Fried Chicken says, you know, we do one thing well. We do nothing but long-term care. And what does that really mean? We look at long-term care from more than a single perspective. We bring an academic orientation to it but in a real-life interaction with State programs and area programs on aging. We teach long-term care to current and future health and social-service providers. We develop and disseminate new ways of providing care to older citizens.

Now, what has the center program accomplished so far in its short 3 years? The regular inclusion of geriatric and gerontological content, including mental health content to future health-care providers and continuing education to those currently working with the elderly. The development, dissemination of innovative and more effective service system delivery mechanisms, for instance the idea of family support groups for the elderly and other programs, and close collaboration with State agencies on aging, for instance around issues that not only deal with the Older Americans Act programs but with medicaid programs as well. We, for instance, work with State units in eight States in our region. This investment has been a cost-effective investment in the sense that about $5 million a year has been spent to try to understand and to reshape the program in the area of the service delivery which amounts to well over $50 billion a year.

I want to give a brief illustration from Florida. In Florida we have the State with the highest population of elderly. While other people are waiting for 20 percent elderly to come in the year 2025, we have wall-to-wall elderly now, with some counties as high as 40 percent over age 60. In Florida we have focused on two issues which I think are of great importance generally.

One is prenursing home assessment in order to seek the limit of total public expenditures of both State and Federal dollars for institutionalized care. We made a very startling discovery by focusing only on medicaid recipients in terms of nursing home assessment. We found that two-thirds of the population who came into this program initially entered by private pay or medicare without such barriers and without such assessments. Any program that would limit access to nursing homes on the basis of real need would have to be extended not only to the poor but to all those seeking nursing home admission.

The second aspect of this is community care for the elderly which is almost totally funded by State dollars in the State of Florida. You cannot have a diverse program for nursing homes unless a broad continuum of service is also available in the community and provides services short of nursing home care.

Two of Florida's neighbor States, the American Georgia rather than Russian Georgia, and South Carolina, are currently experimenting and are interacting with us in Florida around this issue of how to provide alternative ways of delivering services, and we are working very intensively with those areas. Two of these States are considering the role of the area agencies on aging as a final administrator of these programs for community care.

A final word. Long-term care is a long-term issue. It is not going to go away in a year's time. But we are not trying to influence a single issue; we are trying to influence the whole system and we need to bring to bear on it all the relative experiences in the field and all of the other consideration that academia can bring to it. Given the magnitude and the complexity of the problems of long-term care, as well as the fact that a nationwide network of centers now exist which has focused solely on the issue of long-term care, we both selfishly and unselfishly recommend that the Congress in its reauthorization of the Older Americans Act make explicit provisions to support adequately existing long-term care gerontology centers in each of the Federal regions throughout the country.

I will be glad to respond to any questions.

[The prepared statement of Dr. Pfeiffer and responses to questions submitted by Senator Grassley follow:]

TESTIMONY

BY ERIC PFEIFFER, M.D.

Ladies and Gentlemen

I very much appreciate the opportunity to appear before this committee in my capacity as the founding President of the Association of Long Term Care Gerontology Centers and as the Director of the Suncoast Gerontology Center at the University of South Florida in Tampa.

I. Definition of Long-Term Care

In order to keep our discussion on common ground, let me begin with a definition of long-term care. It is a somewhat complex definition but I am not here to tell you there is a simple solution to the problem of long-term care. H. L. Mencken once said: "For every complex problem there is a simple solution, and that solution is always wrong."

Long-term care is the entire system of health and social services required by older persons who, as a result of chronic physical or mental disorder, are experiencing difficulty in living independently.

Long-term care is not simply an issue of nursing home beds but includes home care, ambulatory care, day care, board and care facilities, homes for the aged, life care facilities and, of course, nursing home care. It also includes acute evaluation and treatment facilities incident to long-term care.

2. Long-Term Care as a National Priority

Long term care has now become a national priority, for only one reason - money.

I used to say there were many reasons why long-term care has become important:

> Demographic factors -- you have probably heard enough about those already at this hearing.
>
> Human factors -- concern for the quality of care available to disabled older persons, of course.

But the real reason why long-term care has become a priority at the federal level and at the level of every state legislature is that it is a budget buster.

The rate of increase of expenditures for nursing home care has been phenomenal, rising from 7 billion dollars in 1973 to 18 billion dollars in 1979. More significantly, it is expected to rise to 76 billion dollars per year by the year 1990, conservatively estimated, and to more than 90 billion dollars, by more realistic estimates. 1990 is only 6 years away.

3. THE NEED FOR A LONG-TERM CARE PLAN

THE MAGNITUDE OF THE LONG-TERM CARE PROBLEM REQUIRES THAT WE PREPARE FOR THE GATHERING TIDAL WAVE OF DISABLED ELDERLY IN NEED OF CARE IN A SYSTEMATIC AND COMPREHENSIVE WAY.

THIS IS NOT A FAR-FETCHED IDEA. IN FACT THERE IS PRECEDENT FOR GOVERNMENT PLANNING FOR MAJOR SHIFTS IN POPULATION COMPOSITION. THE GOVERNMENT'S RESPONSE TO THE POST WORLD WAR II BABY BOOM WAS TO BUILD SCHOOLS AND TO TRAIN TEACHERS TO MEET THE NEEDS OF THE BABY BOOM CHILDREN. THE TIDAL WAVE OF ELDERLY PERSONS ALREADY CLEARLY VISIBLE ON THE HORIZON DEMANDS THAT WE DO LIKEWISE FOR OUR MOST EXPERIENCED CITIZENS!

ACCORDINGLY, WE NEED TO DEVELOP AND IMPLEMENT A PLAN TO MEET THEIR SPECIFIC NEEDS. WE DON'T NECESSARILY NEED TO BUILD NEW BUILDINGS OR MORE NURSING HOMES FOR THEM. QUITE THE CONTRARY. WE NEED TO BUILD COMMUNITY-BASED PROGRAMS AND TO TRAIN PERSONNEL TO SERVE THE ELDERLY WITHIN AND OUTSIDE OF INSTITUTIONS MORE EFFECTIVELY. THE CHARACTERISTICS OF SUCH A PLAN MUST BE:

- THAT IT CANNOT AFFORD WASTE OF HUMAN OR FISCAL RESOURCES
- THAT IT CANNOT AFFORD HAPHAZARD OR PIECEMEAL SOLUTIONS
- THAT IT MUST MOBILIZE ALL THE RESOURCES OF GOVERNMENT, PRIVATE ENTERPRISE AND THE ACADEMIC COMMUNITY.

The Long-Term Care Gerontology Centers Program of the Administration on Aging was in fact designed in response to these desired characteristics.

4. The Long-Term Care Gerontology Centers Program as a Response to a National Need

Since September of 1980 a network of Long-Term Care Gerontology Centers has been established, one in each of the HHS regions of the United States, in Rhode Island, in New York, in Pennsylvania, in Florida, in Wisconsin, in Kansas, in Texas, in Utah, in Arizona, in California, and in the state of Washington. These Centers are based in major universities but they interact extensively with community providers and the aging network, including state agencies on aging and area agencies on aging within their respective regions. Each of them constitutes a major resource on long-term care for its own region. Together they constitute a national resource on long-term care.

The Centers are unique in that they do nothing but long-term care. Along the motto of the Kentucky Fried Chicken ad, we concentrate on long-term care and we do long-term care right.

What does that mean?
We look at long-term care from more than a single perspective. We bring an academic orientation to real life programs, and bring the lessons from real life programs back to the university community.

We teach long-term care to current and future health and social service providers. We develop and disseminate new ways of providing care to older citizens. We develop and disseminate new policy options in long-term care. We look at long-term care as a system rather than a series of disarticulated programs.

5. Accomplishments of the Centers to Date

During the short three years of its existence the Centers Program has already achieved some major accomplishments. This despite the fact that only five of the Centers have been operational since 1980, four since 1981 and two only since 1983. These accomplishments have already been summarized by Dr. Russell Mills, but I would like to highlight just a few specific achievements of the Centers. The Centers program has resulted in

- the regular inclusion of geriatric and gerontological content in the training of current and future health professionals, including doctors, nurses, social workers and long-term personnel
- the development and dissemination of innovative and more effective service delivery mechanisms, for instance the development of whole networks of family support groups for patients with Alzheimer's Disease.
- close collaboration with State Offices on Aging and state Medicaid offices concerning policy options regarding long-term care in the several states

- Collaborative research between Centers on such important issues as the determination of active life expectancy, that is expectations for remaining years of independent functioning, rather than total years of survival
- Substantial additional resource development by the individual Centers to expand the capabilities of the Centers beyond that provided beyond AoA funding alone

6. Cost-Effectiveness of the Centers

The considerable accomplishments of the Centers have been achieved at a relatively modest cost. When compared with the massive cost of long-term care services currently estimated at 50 billion dollars per year, the 5 million cost for support of the Long-Term Care Gerontology Centers would appear to be a cost-effective investment. Each of these Centers illuminates the entire range of long-term issues in its own region, as well as contributing to an understanding of long-term care problems nationally. The demonstrated ability of these Centers to be of service to more than one state is a further documentation of the cost effectiveness of this program. For example, the Suncoast Gerontology Center provides assistance on long-term care issues to eight states in the Southeast.

7. An Illustration from Florida

Florida is the state with the highest proportion of elderly of any state in the U.S.A. What the rest of the country will not experience until the year 2000 or even the year 2025, Florida is

ALREADY FACING TODAY. WE CURRENTLY HAVE SOME COUNTIES OF WHICH 40% OF THE POPULATION IS OVER AGE 60; IN OTHER WORDS, WE DON'T HAVE TO WAIT FOR THE YEAR 2000. WE'VE GOT WALL-TO-WALL ELDERLY NOW.

FOR THIS REASON FLORIDA IS TO A SIGNIFICANT DEGREE IN THE SPOTLIGHT, AND OTHER STATES ARE VITALLY INTERESTED IN HOW FLORIDA IS APPROACHING THE LONG-TERM CARE PROBLEM.

TWO CRITICAL ISSUES AROUND WHICH OUR CENTER HAS INTERACTED WITH THE STATE OF FLORIDA HAVE BEEN THE ISSUE OF (A) PRE-NURSING HOME ASSESSMENT OR SCREENING AS A MEANS OF LIMITING FUTURE GROWTH OF STATE AND FEDERAL LONG-TERM CARE EXPENDITURES (B) COMMUNITY CARE FOR THE ELDERLY, AS A MEANS OF LIMITING FUTURE NURSING HOME UTILIZATION AS WELL AS A MEANS OF MAXIMIZING OPPORTUNITY FOR CONTINUED INDEPENDENT EXISTENCE.

FLORIDA CURRENTLY SPENDS APPROXIMATELY ONE HALF BILLION DOLLARS ON MEDICAID PAYMENT FOR NURSING HOME CARE. THIS COST IS SHARED BETWEEN THE STATE OF FLORIDA AND THE FEDERAL GOVERNMENT, ON A FORMULA BASIS. NEITHER CAN TOLERATE THE ANTICIPATED ESCALATION IN THESE COSTS. ACCORDINGLY, A PILOT PROGRAM OF PRE-NURSING HOME ASSESSMENT WAS BEGUN TO LIMIT ACCESS TO NURSING HOMES UNDER MEDICAID PAYMENT TO ONLY THOSE INDIVIDUALS WHO COULD NOT FUNCTION IN ANOTHER SETTING. THIS PILOT PROJECT, HOWEVER, REVEALED SOME STARTLING FINDINGS: SOME 2/3 OF PERSONS SEEKING MEDICAID PAYMENT FOR NURSING HOME COSTS WERE ALREADY IN NURSING HOMES -- INITIALLY

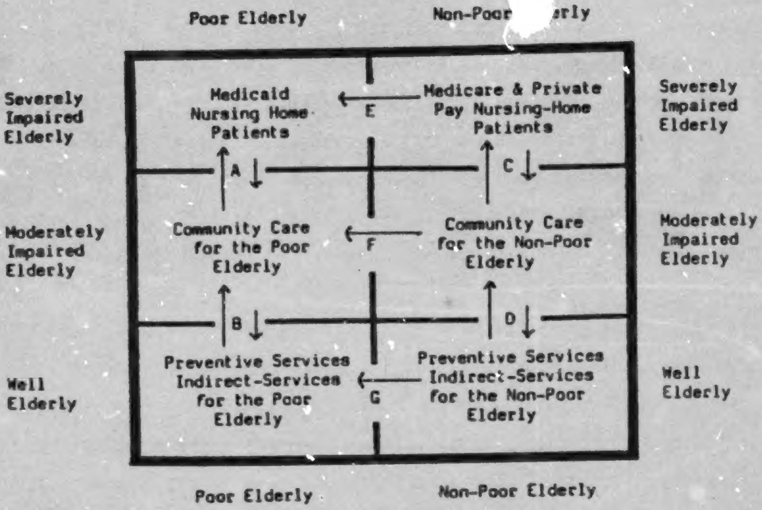
ADMITTED TO NURSING HOMES UNDER MEDICARE OR PRIVATE PAY MECHANISMS, WHERE NO SUCH LIMITATION TO NURSING HOME ADMISSIONS EXISTS. ONCE IN A NURSING HOME, AN INDIVIDUAL COULD ONLY RARELY BE DIVERTED BACK TO COMMUNITY LIVING, HAVING OUTSPENT HIS FINANCIAL RESOURCES AND DISASSEMBLED HIS LIVING ARRANGEMENTS AND FAMILY SUPPORT MECHANISMS. THIS EXPERIENCE TEACHES THAT IN ORDER TO LIMIT TOTAL EVENTUAL USE OF MEDICAID DOLLARS FOR NURSING HOMES, PRE-NURSING HOME ASSESSMENT AND SCREENING WOULD HAVE TO BE APPLIED NOT ONLY TO MEDICAID RECIPIENTS BUT TO ALL OF THOSE WHO SEEK ADMISSION TO NURSING HOMES UNDER ALL PAYMENT MECHANISMS.

THE OTHER ISSUE OF VITAL INTEREST IN THE STATE OF FLORIDA HAS BEEN THE PROVISION OF COMMUNITY-BASED SERVICES UNDER FLORIDA'S COMMUNITY CARE FOR THE ELDERLY PROGRAM. DIVERSION FROM NURSING HOMES IS ONLY POSSIBLE WHEN A STRONG COMMUNITY CARE PROGRAM FOR THE ELDERLY EXISTS. ACCORDINGLY, THE TWO ISSUES ARE INEXTRICABLY INTERTWINED AND NEED TO BE CONSIDERED TOGETHER. ADDITIONALLY, IT BECOMES CLEAR FROM EXAMINING THE FLORIDA EXPERIENCE, AND ESPECIALLY FROM EXAMINING THE MODEL OF TRANSITIONS IN LONG-TERM CARE MORE FULLY EXPLAINED IN THE ATTACHED DOCUMENT, THAT PRE-NURSING HOME ASSESSMENT AND SCREENING AS WELL AS COMMUNITY CARE FOR THE ELDERLY MUST BE AVAILABLE, BOTH FOR THE POOR AND NON POOR INDIVIDUALS IN ORDER TO LIMIT EVENTUAL PUBLIC EXPENDITURES FOR INSTITUTIONAL LONG-TERM CARE.

TWO OF FLORIDA'S NEIGHBOR STATES, SPECIFICALLY GEORGIA AND SOUTH CAROLINA, AND TO A LESSER EXTENT ALL OF THE STATES IN THE

A MODEL OF TRANSITIONS

Eric Pfeiffer, M.D.


Poor Elderly
Non-Poor [illegible]rly
Severely Impaired Elderly
Medicaid Nursing Home Patients
E
Medicare & Private Pay Nursing-Home Patients
Severely Impaired Elderly
A
C
Moderately Impaired Elderly
Community Care for the Poor Elderly
F
Community Care for the Non-Poor Elderly
Moderately Impaired Elderly
B
D
Well Elderly
Preventive Services Indirect-Services for the Poor Elderly
G
Preventive Services Indirect-Services for the Non-Poor Elderly
Well Elderly
Poor Elderly
Non-Poor Elderly

Southeast Region, are currently grappling with these complex issues, and the Center is assisting each of them in evaluating the options available to them.

8. Long-Term Care as a Long-Term Issue

Much as we might wish, the long-term care problems of the nation, at the federal and at the state level, cannot be solved over night. For it is not a single problem which we are trying to address. Rather, we must seek to alter a whole system of health care services and its associated payment mechanisms. In order to change a system, we must have a plan, as already discussed. The Centers have learned to analyze policy options related to long-term care. They are beginning to understand the system as it now works and as it should work. The Centers were organized to assist in this task of developing a long term plan. Their machinery after some three years of operation, is now well oiled and ready to run. Our invitation to all those involved in policy making and policy implementation in long-term care is a simple one: use us.

9. Recommendations

Given the magnitude and complexity of the problems of long-term care as well as the fact that a nationwide network of Centers focused solely on this issue now exists, we both selfishly and unselfishly recommend that Congress in its reauthorization of the Older Americans Act make explicit provision to support adequately the existing Long-Term Care Gerontology Centers in each of the Federal Regions throughout the country.

Responses to Questions by Senator Charles E. Grassley

From Dr. Eric Pfeiffer,
Past President, Association of Long-Term Care Gerontology Centers
and Director, Suncoast Gerontology Center, Tampa, Florida

Question #1: According to the briefing materials the Administration on Aging has made available to the Committee, and as Dr. Mills pointed out in his testimony, the long-term care gerontology centers have several major responsibilities.

What priority is attached to the regional resource role of the centers among these several responsibilities? And do you have any quantitative indicators of this priority?

Response: Serving as a regional resource on long-term care is one of the top priorities of the Long-Term Care Gerontology Centers, along with a responsibility for developing community-based model programs, teaching current and future service providers, and conducting applied and policy research on long-term care.

In quantitative terms 25-30% of Center resources are regularly and directly devoted to serving as a regional resource. Since the other mandated activities (service development, training, research) are also geared to developing the Center as a regional resource in long-term care, it could well be said that some 50-60% of Center resources are actually devoted to this priority.

Question #2: The responsibility to be a resource on a regional basis includes not only state and area agencies on aging but also other state and local actors in the long-term care area.

Just within this regional resource responsibility, can you tell us what priority is attached to the state and area agencies on aging as contrasted with other state and local actors? And do you have any quantitative indicators of this priority?

Response: We consider the state and area agencies on aging to be the principal agencies involved in fulfilling our regional resource responsibilities, far ahead of other provider organizations or agencies.

In quantitative terms, for our own Center, we have been actively involved in collaborative projects with 6 state units on aging in our region, with the Southeastern Association of Area Agencies on Aging in our region, representing all 111 Area Agencies on Aging in our region, and with the Florida Association of Area Agencies on Aging. In addition we have had active collaborative efforts with 5 area agencies on aging in the State of Florida.

In addition the Center's Community Advisory Committee has the Florida State Unit on Aging Director, and four Area Agencies on Aging Directors among its members.

Question #3: According to the briefing materials we have, the centers have been involved in long-term care system development. I believe that it is the case that, as part of this activity, some centers have been involved in development of case management activities.

From your experience in the system development area, do you have any response to the proposal of the National Association of Area Agencies on Aging about the triple-a's long-term care activities? More specifically:

Would you agree that the triple-a's should be the major local area management organization for long-term care? And should the triple-a's move more emphatically in the direction of providing formal case management services?

Response: Our experience indicates that a number of factors strongly favor the increased involvement of AAAs in the long-term care field. The fact that they are universally represented throughout the United States and the fact that they have a strong track record of organizational management makes them very suitable to the coordination of long-term care services. As to providing formal case management services, this is an issue that requires the examination of the current "actors" already involved in case management locally. It might be beneficial for nationwide systems development to have case management be carried by some AAAs and to study the benefits/drawbacks of such an arrangement before making a global decision that all AAAs should be involved in case management activities or that all case management should be carried out by AAAs.

Question #4: What is the purpose of the Association of Long-Term Care Gerontology Centers?

Response: The purpose of the Association of Long-Term Care Gerontology Centers is to develop a knowledge base in the area of long-term care and to disseminate this knowledge base, both nationally and regionally.

Question #5: Can you elaborate on some of the difficulties encountered in trying to work with a large number of triple-a's with differing levels of involvement in long-term care activities?

Response: A large number of AAAs exist in each region in which the Long-Term Care Gerontology Centers are active. Resources are not adequate to develop a full working partnership with each individual AAA. In our region this would amount to 111 such individual arrangements. Instead, we have found it more productive and more practical to work with the regional association of area agencies on aging and the various state organizations of area agencies on aging and at times with and through the state units on aging in the individual states. In addition our Center has strong working relationships with individual AAAs in our immediate service area.

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Senator **Grassley**. Thank you. I will have some.

Dr. Kerschner.

Dr. **Kerschner**. Thank you, Senator. We appreciate being able to testify today and commend you for your continuing involvement and long interest in the problems of older Americans.

I am here today to discuss AARP's cosponsorship of a new health promotion and education program. This program is one important element in AARP's overall health care campaign.

The health care campaign is designed to achieve general goals as follows:

To reduce the rate of cost escalation in health care.

To preserve and strengthen the medicare and medicaid programs and to assure the availability of affordable health care for all citizens.

To encourage the development of such alternative health delivery systems as health maintenance organizations, so-called HMO's.

To develop home health and ambulatory care services that can be more responsive to consumer needs and more efficient in the delivery of care than current institutional systems.

To provide information to consumers on health care costs and options.

And to encourage Americans of all ages to adopt and practice more healthful lifestyles.

Specifically, the AARP's health program creates a vehicle for effective health education by providing program resources designed specifically for older adults and by effectively using existing volunteer and community health resources to meet local needs. The program is cosponsored by AARP and the National Health Screening Council for Volunteer Organizations, a private nonprofit organization which organizes health promotion programs around the country. AARP has been working with them for several years in sponsoring older Americans' health fairs designed for persons age 50 and older and their families.

This is a new year-round program which will feature 1-day programs on different health promotion topics each month, beginning with the model program on cardiovascular health in February, "Understanding Your Heart." The following months will highlight other health topics, including mental health, diabetes, arthritis, and gastrointestinal health. Each 1-day program will involve participants in computerized and interactive learning centers, audiovisual presentations, demonstrations of medical equipment, discussions with health professionals, and appropriate health screening services, including individualized counseling and referral. Individual programs will be held in the community at locations convenient to older citizens: nutrition sites, senior centers, schools, housing complexes, hospitals, et cetera. The program goals are as follows:

To increase awareness of the normal processes of aging, health risks, preventive measures, and health care alternatives.

To motivate individuals to take an active role in maintaining health.

To provide information about alternative health care resources and cost-conscious approaches to selecting services.

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And to link older adults with existing community health resources.

The program is an example of a public and private initiative designed to meet local health needs. Along with the cosponsorship by AARP and NHSCVO, each of the 10 months will be individually sponsored by a corporation which assists with financing and publicity. The Older Americans Act network will also be involved. State units on aging, area agencies on aging, senior centers and nutrition sites have taken an active role in planning the model cardiovascular health program in many areas of the country, including Arizona, California, Florida, Ohio, Oklahoma, Indiana, Maryland and Connecticut. The area agencies on aging in Connecticut are taking the lead in planning and organizing five cardiovascular health sites, one in each planning and service area of the State. The Ohio Commission on Aging will cosponsor a site with the Franklin County Area Agency on Aging and AARP at the State capitol in Columbus. Many other community service and professional organizations in health care and gerontology are becoming involved in planning to implement the program to meet local needs.

The program has been created to provide an accessible, educational environment where older persons can learn about their health in order that they may lead active, vital and more satisfying lives. Through interactive, experiential learning, AARP's health program will promote independence and healthy lifestyle choices among older consumers. The program will also focus on the fact that individuals can make a difference in their health status, life expectancy, how they feel about themselves and others, and what happens in their community. The impact of these lifestyle changes can help reduce health care out-of-pocket expenditures for individual consumers.

This program, we believe, can be replicated throughout the country at a comparatively low cost and with high potential dividends for older Americans, especially those who may otherwise become candidates for premature institutionalization.

Thank you, Senator.

[The prepared statement of Dr. Kerschner and responses to questions submitted by Senator Grassley follow:]

STATEMENT OF DR. PAUL A. KERSCHNER

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify before the Subcommittee on behalf of the American Association of Retired Persons. I am here today to discuss AARP's co-sponsorship of a new health promotion and education program called Focus on Health. This program is one important element in AARP's overall health care campaign.

Over the past decade, health care costs have risen at more than double the general inflation rate. Health care cost escalation threatens the financial status of the Medicare and Medicaid programs and the affordability of adequate health insurance coverage for all Americans. At stake is access to affordable health care for everyone.

Medicare's deteriorating financial condition is merely symptomatic of fundamental weaknesses in the nation's health delivery system and practice. Only across-the-board, system-wide reforms applicable to all providers and purchasers can solve Medicare's problems and meet the health care needs of all citizens.

AARP's health care campaign is designed to achieve these general goals:

*To reduce the rate of cost escalation in health care

*To preserve and strengthen the Medicare and Medicaid programs and to assure the availability of affordable health care for all citizens

*To encourage the development of such alternative health delivery systems as Health Maintenance Organizations, *home health and ambulatory care services that can be more responsive to consumer needs and more efficient in the delivery of care than current institutional systems

*To provide information to consumers on health care costs and options

*To encourage Americans of all ages to adopt and practice more healthful lifestyles

While an immediate goal of this campaign is to strengthen Medicare, AARP believes that encouraging healthy lifestyles is important over the longterm. Focus on Health is a year-long, nationwide health promotion and education program which will help thousands of older persons learn more about their health so they can lead more active, vital lives.

Background

America is aging. In 1982, there were 26.6 million people aged 65 or older. Projections for the next several decades show that the population 75 years of age and over is expected to increase four times faster than that of persons under age 65. The proportion of the elderly who are aged 75 and older is important because the incidence of chronic disease and impairment and the utilization of medical services tends to increase with age, and increase dramatically after age 75.

The aging of America present serious questions regarding the future:

*will we remain an active, vital population?

*what will be the quality of our lives as individuals in our later years, and as we live longer?

*will we be able to contain health care costs?

*will more and more of our national resources need to be directed towards caring for an increasingly infirm or chronically ill population?

The answers to these questions are important to the future well-being of the nation. Steps to encourage the preservation and maintenance of good health among all adults, including older adults, are important. Millions of lives have been saved from acute heart attacks, strokes, early death from cancer, diabetes and other acute conditions. Information exists which can help older persons learn how to prevent or control disease, and to better manage chronic, degenerative disease, which has tended to become the dominant pattern of illness. Prevention, health promotion, and detection of disease in early, treatable stages can reduce the overall cost of health care for individuals, helping them to limit out-of-pocket health expenditures. Appropriate health education can also help older adults be more independent and take control of their lives, contributing to a higher quality of life. But, we must also realize that these approaches will not solve Medicare's current funding problems.

The Focus on Health program creates a vehicle for effective health education by providing program resources designed specificially for older adults, and by effectively using existing volunteer and community health resources to meet local needs. The program is co-sponsored by AARP and the National Health Screening Council for Volunteer

Organizations (NHSCVO), a private, non-profit organization which organizes health promotion programs around the country. AARP has been working with NHSCVO for several years in putting on older Americans' health fairs.

Designed for persons aged 50 and older and their families, Focus on Health is a new, year-round program which will feature one-day programs on different health promotion topics each month. Beginning with the model program on cardiovascular health in February, called "Understanding Your Heart", following months will highlight other health topics including mental health, diabetes, arthritis, and gastrointestinal health. Each one-day program will involve participants in computerized and interactive learning centers, audiovisual presentations, demonstrations of medical equipment, discussions with health professionals, and appropriate health screening services, including individualized counseling and referral. Individual programs will be held in the community at locations convenient to older citizens: nutrition sites, senior centers, schools, housing complexes, hospitals, etc.

The program goals are to:

*increase awareness of the normal processes of aging, health risks, preventive measures, and health care alternatives;

*motivate individuals to take an active role in maintaining health;

*provide information about alternative health care resources and cost conscious approaches to selecting services; and *link older adults with existing community health resources

The Focus on Health program is an example of a public-private initiative designed to meet local health needs. Along with the co-sponsorship by AARP and NHSCVO, each of the ten months will be individually sponsored by a corporation which assists with financing and publicity. The Older Americans Act network will also be involved. State Units on Aging, Area Agencies on Aging, senior centers and nutrition sites have taken an active role in planning the model cardiovascular health program in many areas of the country, including Arizona, California, Florida, Ohio, Oklahoma, Indiana, Maryland, and Connecticut. The Area Agencies on Aging in Connecticut are taking the lead in planning and organizing five cardiovascular health sites, one in each Planning and Service Area of the state. The Ohio Commission on Aging will co-sponsor a site with the Franklin County Area Agency on Aging and AARP at the State Capitol in Columbus. Many other community service and professional organizations in health care and gerontology are becoming involved in planning to implement the program to meet local needs.

The Focus on Health program has been created to provide an accessible, educational environment where older persons can learn about their health in order that they may lead active, vital and more satisfying lives. Through interactive, experiential learning, Focus on Health will promote independence and healthy lifestyle choices among older consumers. The program will also focus on the fact that individuals can make a difference in their health status, life expectancy, how they feel about themselves and others, and what happens in their community. The impact of these lifestyle changes can help reduce health care out-of-pocket expenditures for individual consumers.

In conclusion, we appreciate the opportunity to participate in this hearing, and we want to reaffirm the Association's willingness and readiness to work with the Subcommittee in developing a more rational approach to meeting the long term care needs of the elderly. The Focus on Health program addresses what we consider to be a major gap in our nation's long term care approach -- the need to develop more effective preventive and educational measures to delay, curb or control the onset of chronic or disabling diseases. This program, we believe, can be replicated throughout the country at a comparatively low cost and with high potential dividends for older Americans, especially those who may otherwise become candidates for institutionalization.

QUESTIONS FOR PAUL KERSCHNER FROM SENATOR CHARLES E. GRASSLEY

Q. 1. I want to congratulate the AARP on the initiative in health screening and health education it will undertake this spring. It seems to me that this is a very important national effort which deserves the appreciation of this Subcommittee.

The project AARP is starting calls attention to the importance of forestalling the onset of chronic illness or disability which can be financially and emotionally very burdensome.

In the rush to develop community long-term care services are we running the risk of overlooking this very large group of older people who are relatively well and who we need to keep well as long as possible?

A. (AARP)

A need exists for the development and implementation of a long-term care program that provides a complete continuum of services - medical, health, social and personal care services provided in a variety of settings. The Health Focus program addresses what we consider to be a major gap in our nation's long-term care approach -- the need to develop more effective preventive and educational measures to delay, curb or control the onset of chronic or disabling diseases. The Health Focus program has been created to provide an accessible, educational environment where older persons can learn more about their health in order that they may lead active vital and more satisfying lives. Through interactive, experiential learning, Health Focus will promote independence and healthy lifestyle choices among older consumers. This program is focused on the population of older adults that is relatively well, and aims to prevent and detect disease in early treatable stages and to promote healthy lifestyles. This type of health promotion activity should be included in a long-term care plan for older adults.

Q. 2. I presume that AARP gave considerable thought to this initiative before starting it. Has the AARP done any estimates of what effect on what we might call the long-term care burden can be achieved by a comprehensive health maintenance screening program with follow-up activities of the sort AARP is going to undertake?

A. (AARP)

The Health Focus program is designed to encourage healthy lifestyles for older adults over the long term. While prevention and health promotion can reduce the overall cost of health care for individuals, helping them to limit out-of-pocket health expenditures and contribute to a higher quality of life, these approaches will not solve the immediate problems of Medicare's imminent insolvency and the escalating cost of health care for all Americans.

We can only predict what the effect of this program might be on the long-term care burden. It is generally understood that the elderly are better served when they are helped in maintaining their independence in their homes and communities as long as possible. Yet, the federal government spends more to maintain older persons in nursing homes than it does on the combined cost of home care under Medicare/Medicaid, all social service programs, and all federally funded special housing programs for the elderly. An analysis of existing Federal programs for the delivery of health care and social services reveals an obvious bias in favor of acute care -- not chronic care -- and institutional long-term care -- not long-term services in the home or community. Furthermore, when it comes to in-home services, community services, special living arrangements, nursing home care and other forms of long-term care at the state or local level, there has been no serious, comprehensive effort from the federal level to encourage the linkage and coordination of the management of these services within the community. The Health Focus program creates a vehicle for effective health education by providing program resources designed specifically for older adults, and by effectively using existing volunteer and community health resources to meet local needs. In this way the Health Focus program aims to prevent, delay or control the onset of chronic or disabling diseases. The achievement [illegible] this goal can have a major effect on the long-term [illegible] burden of these chronic diseases.

Q. 3. You have worked with aging program for some time and know the Older Americans Act programs. Are you able to comment for our hearing record on the proposal of the N4A to amend the Act to refocus Title III activities more emphatically on long-term care and to make area agencies responsible for case management activities?

A. (AARP)

AARP does not favor converting Title III into a community-based, long-term care program because there are not sufficient resources under Title III-B (current funding is $240.9 million) to accomplish this mission. Other programs (e.g., Medicaid, Medicare, and Title XX) are more appropriate for long-term care or case management because these programs have substantially greater resources than Title III. An emphasis on community-based, long-term care activities would siphon off funds for other services under the Older Americans Act (e.g., transportation, nutrition, legal, and others).

Senator **Grassley**. Thank you very much.

I am going to take a few minutes for questions, even though it has run a little bit later because we have a couple of things here that we ought to discuss further.

I will start with you, Mr. Meek, and it is about your point on quality assurance. And I will have to say that it is certainly well taken.

Do you happen to know how the home care program funded under title III of the Older Americans Act provides for quality assurance?

Mr. **Meek**. I am not sure, but I do not think that there are any provisions under title III that would really address that subject, except indirectly. There is nothing in title III, there is nothing in the Older Americans Act, that really addresses the subject of how good anything is. "How much it is" is in there, but "how good it should be" is not there, except to the extent that certain professionals who provide certain services have basic skills. You assume that, for example, a nurse knows her job. But there is nothing that I know of in the act on the general subject of quality, nor is there anything particularly at the State or local level.

Senator **Grassley**. Well, I think we ought to ask the commissioner then how they assure quality.

Mr. **Meek**. It would be interesting.

Senator **Grassley**. I will pursue that.

Mr. **Meek**. You hear the term "quality assurance" everywhere, everybody uses it. But I think you might ask the question of the Commissioner as to how they do assure quality.

Senator **Grassley**. I will open dialog with the Commissioner on that point then.

Dr. Kerschner, I am not sure whether or not you can comment on this today, but let me put a question to you anyway. And this involves our July hearing with the Commissioner on Aging where she describes some of the health promotion activities that she is undertaking at HHS, and I understand that she places high priority on health promotion activities.

Do you think that the Older Americans Act as it now stands permits the State and area agencies to engage as fully as they wish in health promotion activities?

Dr. **Kerschner**. I think the Older Americans Act permits it, Senator. I think it is not a question of whether there is a need for more legislation or redefinition of the Older Americans Act. In fact, under this renewal, I would hope that we do not make major substantive changes in the act. I think what is required is administrative in nature and that is a decision on the part of the Administration on Aging as well as other parts of HHS, to push for health promotion and health maintenance activities. I think it is there in the act. I know there are those who would have a new title VII that would strictly push for health promotion activities. That would be fine. We are not against that. It is just that we do not want to see other parts of the Older Americans Act reduced in terms of funding in order to fund another part.

If there is new money available, fine. I think that is something that should be done under the Older Americans Act. We would not like to see old moneys taken and put into a new part of the Older

Americans Act. So I guess the short answer is yes, you can do it in the act, and, no, you do not need new legislation to do it.

Senator **Grassley**. Thank you.

Now, to Dr. Mills and Dr. Pfeiffer.

I understand that the Regional Program Directors of the Administration on Aging are responsible for providing guidance to the long-term care gerontology centers in their role as resources for State and local public and private agencies.

In your experience, have the regional directors been helpful in identifying the needs of the State and local public and private agencies in long-term care area?

Dr. **Mills**. In my experience, yes. I deal with the one in Kansas City and he is extremely helpful, and we communicate very often.

Senator **Grassley**. Dr. Pfeiffer.

Dr. **Pfeiffer**. Yes, very much so. Our regional director in Atlanta has helped us specifically in trying to characterize the quite major differences between the various States in the Southeast, between Alabama, Mississippi, the two Carolinas, and so on. They have a book on each of the States which has facilitated our interaction with them, and they have been particularly helpful in pointing out organizational differences in the area of long-term care. In some of these States, the State Unit on Aging has almost primary responsibility for long-term care. In other States, it is only one of a series of players in this area, and I think they have given us access to this information and access to the proper people. They have been most supportive of allowing us to service eight different States in our region to provide technical assistance and long-term care.

Senator **Grassley**. Could I probe a little further how they might do this, and you described a little bit, but is there a more or less formal planning process or do the centers respond on an ad hoc basis as the demands come upon them?

Dr. **Pfeiffer**. We have asked the regional director to convene at our center all the State Unit on Aging Directors of the several States and have engaged in a 2-day long discussion, mutual negotiation of the areas in which we would be helpful during the coming year with these individual State Agencies on Aging.

Dr. **Mills**. I meet regularly with the regional officer, and in his meetings with the State unit directors, and we are scheduled to have individual visits from the State unit directors at our center. Most of the State unit directors in region 7 are fairly new at the long-term care game. So it is very much an educational process.

Senator **Grassley**. OK.

Again to Dr. Mills and Dr. Pfeiffer, and this is in regard to funding.

It is my understanding that the centers are free to seek funds from sources other than the administration. In fact, I understand that the centers are to look forward to eventual fiscal independence from the Administration on Aging.

Have you received funds from other sources, and how much of your center's budget is attributable to these sources?

Dr. **Pfeiffer**. In regard to our center at the moment, we have reduced the amount of funding for the center operation funded by the Administration on Aging to about 50 percent of the total funding from where it started out at—it was at about 90 percent. So we have increased that funding from other sources by that magnitude, and I believe all of the other centers are engaged in a deliberative effort to find such funding sources.

But given the magnitude of trying to travel in an eight State region and trying to assist major State agencies, sizable ongoing support I think as a kind of a leavening effect on the region, I think will be necessary. I think if this funding were discontinued, the programs would not survive. I think if they were continued over to a substantial period longer, they might survive on their own.

Dr. MILLS. Forty percent of our operational budget is stable State support. About 15 or 20 percent is other grants such as training grants from the Nurse Training Act.

The stable State support from Kansas can reasonably be expected to pay, I think, only for activities in Kansas. And if the operations of the centers are valuable in other States, then I think some Federal funding has to come.

Senator GRASSLEY. Dr. Pfeiffer speculated on what would happen if there was not some Federal funding.

Do you have a point of view on that?

Dr. MILLS. Yes, I do. I think our center would be forced to draw in its horns to the State boundaries of Kansas. Unless the State units and area agencies outside of Kansas were willing to come up with consultation and contract funds that could purchase what they needed from us.

Senator GRASSLEY. I want to thank this panel for your participation, thank every panelist. I think we had an outstanding series of witnesses and experts in their area to testify, and this is one of four or five hearings that we are going to have this year leading to subcommittee reconsideration of reauthorization, hopefully the last of March, and on the floor of the Senate by the first week in May.

[Additional material supplied for the record follows:]

QUESTIONS FOR LENNIE-MARIE P. TOLLIVER, Ph.D., Commissioner on Aging FROM SENATOR CHARLES E. GRASSLEY

Q-1

ASSURANCE OF QUALITY HOME CARE SERVICES

QUESTION: At both our July, 1983, hearing on long-term care and our recent hearing on Long-Term Care Under the Older Americans Act, witnesses stated that assurance of quality in home care services could be a problem. That is, the rapid burgeoning of home care services could be accompanied by fraud, abuse, or low quality services. Can you describe for us the way in which the Older Americans Act network assures high quality in the home care services it provides under terms of the Act? Do you think that quality assurance procedures are now adequate? What steps has the Administration on Aging taken to insure high quality services in the home care area?

ANSWER:

- The aging network assures high quality in the provision of home care services by funding, evaluating and monitoring these services. Specifically, Area Agencies on Aging evaluate the effectiveness and the use of community resources used in meeting the need for home care services, and allot a proportion of their supportive services funds to service providers, through grants and contracts, to provide these services in a comprehensive and coordinated manner. State Agencies on Aging also evaluate the need for home care services on a statewide basis and determine the extent to which existing public and private programs meet such need. Periodically, State Agencies evaluate activities and projects funded and carried out under the State plan.

- State and Area Agencies are monitoring the quality of these services in their respective jurisdiction. Additionally, we think that the requirements in the Act for the assurance and provision of comprehensive and coordinated service delivery systems continue to give State and Area Agencies the flexibility to develop and publish methods of home care service delivery which ensure that quality services are provided.

- In order to assist State and Area Agencies on Aging to ensure a high quality of services in the home care area, the Administration on Aging has implemented an initiative designed to increase the capacity of these agencies to develop community-based approaches to long-term care. This initiative is multi-year, multi-stage, and focuses on a series of self-assessment, training, technical assistance, and information dissemination activities. These activities are expected to be carried out through a variety of auspices which include the FY 1985 Education and Training Program, the regional resource activities of the Long-Term Gerontology Centers, and information dissemination carried out by AoA Central Office. We have taken this approach because virtually all issues of concern to older persons with regard to home care services require, for their resolution, the commitment of community-based organizations in the voluntary and private sectors, as well as the continued efforts of local public agencies.

Q-2

CERTIFICATION OF HOME CARE AGENCIES

QUESTION: One of the witnesses at our recent hearing, Mr. Peter Meek, representing the National Home Caring Council, advocated certification of home care agencies by organizations such as his own before they would be permitted to provide home care services under terms of the Act. Apparently, Mr. Meek's group made a formal suggestion to the Health Care Financing Administration along these lines. Do you think that certification of the sort that Mr. Meek advocates is advisable?

ANSWER: The Administration on Aging has never imposed a Federal requirement of certification on providers in order to participate in our program. While we strongly support effective means of assuring high quality of care, we do not believe that a Federally required certification process will necessarily achieve this goal. In our experience, we find the needs in local communities so diverse that the imposition of Federal requirements would only diminish the ability of local communities to respond. In addition, such Federal requirements would almost necessarily increase the cost of care without the guarantee of increasing the quality of care. In these fiscally constrained times, increased costs could lead to a decrease in service availability, which we strongly oppose. For these reasons, we do not think Federal certfification is advisable. However, where a system of voluntarry certification exists, or when a local area finds such a certification process useful, we would certainly support the concept. Our program regulations, in fact, prescribe that all services funded with Older Americans Act Title III funds must meet any existing State and local licensure and safety requirements.

MENTAL HEALTH UNDER SECTION 422(b)(1) OF THE ACT

QUESTION: The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging asserted in its statement before the Subcommittee that the Administration has not issued a grant announcement which incorporates the range of issues identified in Section 422(b)(1) of the Older Americans Act. I have asked the Action Committee to provide the Subcommittee with a more detailed analysis which might support their claim. Can you comment please on this assertion? Do the Long-Term Care Gerontology Centers on the Channeling Demonstrations respond to the requirements of Section 422(b)(1)?

ANSWER: During the last two years, AoA has awarded several grants in areas pertaining to mental health in compliance with Section 422(b)(1). A description of these awards appears below. AoA has also collaborated with the National Institute of Mental Health and recently signed an agreement with them to increase activities in this area. Awards for demonstration, education and training, and special activities by Long-Term Care Gerontology Centers include:

o A grant to the Wisconsin Department of Health and Social Services, Division of Community Services, Bureau of Aging, Madison, Wisconsin.

Project Award:	$100,000
Project Period:	9/30/82 - 3/30/84

To enhance and increase mental health services to the elderly through more effective coordination between mental health and aging agencies at the State, regional, and county levels. The purpose of this coordination is for creating acceptable, accessible, cost-efficient, and replicable peer counseling models within the framework of current service systems. Specific objectives area:

1. Establish State goals and policies to increase mental health services to the elderly.
2. Establish cost-effective and replicable models for mental health services to older persons.

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3. Expand local mental health service to the elderly through local cooperative program planning and advocacy.

4. Deveop a project for nationwide dissemination to provide a model for a one-year planning and program development process to increase services to the elderly.

o A grant to the Michigan Office of Services to the Aging, Lansing, Michigan.

Project Period:	9/30/82 - 7/31/84
Project Award:	$102,500

This project facilitates interagency linkages among local providers of mental health and aging services through replicable methods of knowledge transfer and information dissemination. Specifically, this project has developed materials which are designed to increase local level interagency interaction between the public mental health system and the aging network. These two projects (Wisconsin and Michigan) demonstrate building ties to the mental health system.

o A grant to the Mental Division, Department of Social and Health Services, Olympia, Washington.

Project Period:	9/30/81 - 12/30/83
Project Award:	$180,000

To develop a model for collaboration between the aging network and the mental health system in order to increase the accessibility of a full range of mental health services to the elderly.

Specifically, this project prompted collaboration in the following ways:

1. The frail/impaired elderly were identified as a common target population.

2. A State level interagency work group was appointed to systematically resolve coordination problems between the aging network and mental health system.

3. Several local aging/mental health work groups were organized to continue collaborative efforts in meeting the mental health needs of the elderly.

- A grant to the University of Bridgeport for a program which offers undergraduate coursework at the certificate, associate and bachelor degree levels for students who are currently working or plan to work in the mental health field serving older persons.

- A grant to the University of Southern California (Los Angeles) to increase the number of professionals trained in mental health and aging, and to develop and evaluate the program innovations that address traditional barriers to mental health service use and better professional training. The project will compile a casebook, foster ties with the Aging Network and administer an expanded clincal training site.

- As part of the FY 1984 Coordinated Discretionary Funds Program in Gerontological Training, grants will be made to colleges and universities for the inclusion of gerontological content in the training of students in professional and paraprofessional areas wich include health and mental health care, as well as a host of other areas.

- In the area of Long-Term Care, the Long-Term Care Gerontology Centers (LTCGC) have provided technical assistance in the mental health field.

  - University of Washington, LTCGC has worked with the Washington State Aging and Mental Health Task Force to design programs that have greater accessibility for the elderly.

  - The Mid-Atlantic LTCGC is working with the Pennsylvania Department of Aging and the Office of Mental Health, Pennsylvania Department of Welfare, to develop a memorandum of agreement designed to foster a cooperative working relationship. An initial outcome was a demonstration project in Luzerne County which brought together 70 aging and mental health personnel in a training and practice environment.

-- The Suncoast Gerontology Center at the University of South Florida in Tampa has developed a specialized clinic for clients with Alzheimer's Disease. The Center also produced two major training films emphasizing the disorder, established a statewide network of Alheimer's Family Support Groups and developed a technical assistance manual for others who are interested in developing such groups.

In addition to these funded project, AoA and NIMH recently signed a Memorandum of Understanding. Activities will include:

- Education and training programs will be developed to improve the capacity of practitioners and those preparing for careers in the field of aging.
- Surveys of mental health facilities to determine the degree to which aging patients are being served will be conducted.
- State and Area Agencies on Aging will identify their technical assistance needs in the area of mental health.
- The Aging Network will be encouraged to support and sponsor State and local symposia, conferences, in-service training and the publication of resource guides and manuals.
- State Mental Health Authorities and State Agencies on Aging will be informed of the legislative directives of the Older Americans Act of 1965, as amended, and the Alcohol and Drug Abuse and Mental Health Services Block Grant emphasizing the focus on mentally ill elderly individuals.
- Area Agencies on Aging will be encouraged to work with community mental health organizational staff to develop treatment plans that respond to the social needs of elderly mental health patients and to expand treatment programs of long-term facilities to include mental health services. AoA and NIHM will work together to launch a promotional campaign with national organizations to emphasize concern for mental health needs to the elderly.

Q-4

NATIONAL ASSOCIATION OF AREA AGENCIES PROPOSAL ON LONG-TERM CARE

QUESTION: Has the Administration on Aging taken a position on the proposal of the National Association of Area Agencies on Aging on long-term care under the Act? If so, may we have it for our hearing record?

ANSWER: Basically, I think that the aging network should be involved in the planning and decisionmaking regarding long-term care because of its knowledge of older persons and its access to them. The current law provides sufficient authority to area agencies to assume greater responsibility in the area of long-term care. However, the exact nature and extent of involvement by Area Agencies on Aging in long-term care should remain a local decision.

Q-5

PRIMARY CARE FOR MENTAL HEALTH

QUESTION: Would you say that the primary care for the mental health of the elderly rests with the mental health system proper, rather than with the Older Americans Act network? If this is the case, what is the proper role of the network in assuring that mental health services are provided to older people in need of such services?

ANSWER:

- o Yes, I agree that the primary care for the mental health of the elderly rests with the mental health system. The Federal, State and local agencies that make up the mental health system are responsible for designating community mental health catchment areas; planning, developing, and operating community mental health centers; and coordinating with State and local mental health institutions. These activities require a considerable amount of highly technical training and expertise, and in my opinion are not the types of activities that agencies and organizations within the Older Americans Act network can or should have as primary responsibility.

- o However, the Older Americans Act network does have a role in assuring that mental health services are provided to older people in need of such services. Through the provision of a comprehensive and coordinated system of supportive services, Area Agencies on Aging can assist mental health agencies and organizations by assisting with outreach efforts, furnishing appropriate technical assistance, and establishing effective assistance, and establishing effective and efficient procedures for coordination between programs. When appropriate, Area Agencies on Aging can and do enter into agreement with providers of mental health services for the provision of such services to older individuals who need them.

Q-6

AoA ROLE RESPECTING PROSPECTIVE PAYMENT SYSTEM

QUESTION: One of our witnesses, Mr. Steve Farnham, a triple-a director from Maine, argued that after a period during which there were no people waiting for nursing home placement, there are now waiting lists for nursing home placement in Maine. He attributed this to the advent of the prospective payment system of hospitals in treating Medicare eligibles. Another witness, Dr. Sharon Patten, argued in her statement that the Older Americans Act network should have a role in monitoring the consequences for older people of the working of the the new system?

ANSWER:

- o Insuring the success of the new prospective payments system and assuring high quality care is one of the Department's most important priorities. Specifically, the Health Care Financing Administration (HCFA) is monitoring this new system in three major ways:

  1) A group, under the auspices of the Deputy Administrator of the HCFA, was established specifically to monitor the impact of the prospective payment system.

  2) The impact of the system is being assessed and monitored locally by the Peer Review Organizations, or PRO's, as authorized by P.L. 98-21. These organizations will be responsible for the review of all Medicare admissions nationwide. These organizations examine appropriateness of admissions and quality of care among other things, and will be held accountable for achieving quality objectives.

  3) The Office of Research and Demonstrations (ORD) in HCFA has undertaken impact studies to examine how the system affects providers, beneficiaries and other payees as well as to develop recommendations to Congress for changes in the system.

- o With all this activity, we believe it would be duplicative and unnecessary to initiate new studies under the Older Americans Act. We are in contact with the Health Care Financing Administration and when relevant information becomes available, we will issue it to our network.

QUESTIONS FOR PAM WEST FROM SENATOR CHARLES E. GRASSLEY

Question 1: At both our July 1983 hearing on long term care and our recent hearing on Long Term Care Under the Older Americans Act, witnesses stated that assurance of quality in home care services could be a problem. That is, the burgeoning of home care services could be accompanied by fraud, abuse, or low quality care. Do you think that quality assurance procedures are now adequate in federally funded home care services? From what you know of the Older Americans Act programs do you think that quality assurance protections are adequate in it?

Response 1:

The question of quality assurance of services provided under government funded programs has been a serious topic of discussion for many years. As you indicated, the programs contracted under Title III of the Older Americans Act (OAA) have not been immune from these questions of quality assurance. Yet, the experience of Home Health Services and Staffing Association (HHSSA) members with these programs demonstrates that problems of quality assurance for home care services have not been shown to be a major problem.

HHSSA believes that the contracts entered into with the OAA's area agencies have functioned to assure the provision of quality services. The contracts which exist between managing agencies and service providers afford the most effective mechanism for controlling quality of care, proper financial reporting and appropriate utilization of employees. These outcomes can be assured through "built-in" mechanisms in the contract requirements. The agency managing the contracts holds the responsibility to make certain that these specifications are included.

For example, the contracting agency should ask for such things as the clients bill of rights, a philosophy of nursing practices statement, as well as information on any specialized traini[illegible] of the care givers that will be needed to serve the contract. Supervisory skills and the standards for supervision required to meet the contract needs should also be spelled out before the contract is offered to the provider.

The providers of services, on the other hand, should always provide a statement of their commitment to both quality control, good business practices and adherence to professional standards. Home care companies that are actively involved in meeting today's needs will have all this information. The request for proposal should consider this information to be of critical importance and its documentation to be essential before the contract's completion.

Moreover, the Older Americans Act programs have the built-in advantage of working with clients who are able to respond to program abuses by notifying the contracting or supervising agency. Thus, program participants play a contributing role in monitoring quality assurance performance of providers.

It should also be kept in mind that the contractual agreement provides the area agency with the authority to terminate the services of any unsatisfactory provider. This gives the area agency the right--and, in our opinion, the obligation--to cancel a contract with a home care agency delivering an unacceptable level of quality of care.

HHSSA believes that the OAA possesses adequate safeguards to ensure the delivery of quality care. The experience of our members continues to demonstrate the effectiveness of the contract between the area agency and the provider in assuring the quality of Title III home care services.

Question 2: Mr. Meek advocated at our January 31 hearing accreditation of home care agencies by organizations such as his own before they would be permitted to provide home care services under terms of the Act. Do you think that certification of the sort that Mr. Meek advocates is advisable?

Response 2:

In his testimony on behalf of the National Home-Caring Council (NHCC), Mr. Meek advocated the "accreditation" of agencies providing services under Title III of the Older Americans Act (OAA). We would like to make it clear at the outset, that our Association is not opposed to the concept of accreditation. However, HHSSA does not believe accreditation--by the NHCC or any other standards-setting body for OAA programs--is either necessary or advisable at this time. In our opinion, the establishment of a separate accrediting program for OAA programs would 1) duplicate the function of the contract between the area agency and the provider, 2) decrease the flexibility of standards, 3) increase adminstrative costs and time-requirements of providers and, 4) confuse the quality assurance process through a variety of standards.

First, as specified in our response to question #1, the contract between the provider of home care services and the contracting agency was established as the appropriate place for assurances of quality. Our experience has shown that the contract has functioned satisfactorily to assure the delivery of home care services. HHSSA believes that the responsibilities for safeguards against fraud, abuse or poor quality of service rest with the contracting agency and should not be assigned to any other regulatory or standard-setting body. Accreditation by a separate private organization or the incorporation of a certification program into federal regulations would only duplicate the existing function now served by the contract.

Secondly, since the OAA attempts to meet many different social service needs, the establishment of a broad ranging quality control or standard-setting program would likely prove cumbersome and unwieldy from a bureaucratic standpoint. Further, flexibility of standards afforded through the use of the contract in meeting the requirements of varying local communities would be greatly diminished by a nationally administered accreditation program.

Thirdly, it is both time-consuming and of considerable expense for agencies to document compliance with standards and to go through an accreditation process. Administrative costs would only burgeon at a time when cost consciousness is essential. In a time of scarce resources--particularly scarce governmental funds--we think there may be an understandable reluctance on the part of providers to undertake these burdens. This would be especially true where an adequate quality assurance mechanism is already in place.

Our final concern with respect to the implementation of an accrediting program for OAA programs lies in the diversity of standards that already exist in both governmental and private accrediting bodies. No one uniform set of standards exists.

These overlapping and competing standards only serve to add an element of confusion to the process of assuring quality of delivered services. We would support the notion that these varying requirements be catalogued and compared and, if possible, consolidated before one particular program is selected to oversee the quality assurance process.

HHSSA believes that more emphasis should be placed on the proper drafting of contracts and requests for proposals rather than implementing a separate accreditation program. A properly written contract accurately defines standards of performance, definition of terms, and the responsibilities of each party. Similarly, a properly written contract is easily monitored to assure quality of care.

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STATEMENT OF THE
AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION
A DIVISION OF THE
AMERICAN ASSOCIATION FOR COUNSELING AND DEVELOPMENT
(Formerly American Personnel and Guidance Association)

BY
EDWARD S. BECK, Ed.D., CCMHC, NCC
PRESIDENT
AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION
THE PENNSYLVANIA STATE UNIVERSITY - CAPITOL CAMPUS
MIDDLETOWN, PA

BEFORE THE

U.S. SENATE SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES

ON
JANUARY 31, 1984

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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE;

I am pleased to present testimony to your Subcommittee regarding Long Term Care and the Older Americans Act. I represent the American Mental Health Counselors Association, a division of the 42,000 Member American Association for Counseling and and Development (Formerly American Personnel and Guidance Association).

Mental Health Counselors perform services in a variety of settings to a wide variety of clientele, including a large portion of America's elderly population. On a daily basis we encounter the many complex and frustrating long term emotional and mental difficulties that are common among our nation's Senior Citizens. Thus, we are enthusiastic about and supportive of the Older American Acts' Declaration of Objectives that states that older Americans are entitled to "The best possible physical and mental health which science can make available and without regard to economic status". We agree with the other four core provider groups that the mental health needs of the aged can be effectively dealt with, and that merely because a person happens to be elderly, all hope is not lost.

The charge of the Older Americans Act is inspiring to us, particularly sections that provide for the establishment of demonstrations projects in the areas of: Location of individuals who are in need of mental health services, the specification of the mental health needs of older individuals, and the mental health and support services required to meet such needs, and the actual provision of mental health services. Yet, as you are most likely aware, to the best of my knowledge, none of these demonstration projects have been implemented or funded. We recommend that during your consideration of the OAA reauthorization, that your amendments specifically provide for the implementation of this section through the timely issuance of regulations as well as the proper allocation of funds.

The American Mental Health Counselors Association would also like to recommend that Area Agencies on Aging develop and strengthen their working relationship with Community Mental Health Centers. This would clearly enhance the effectiveness of providing for the Psycho-social needs of the elderly.

Finally, there are other provisions of the Older Americans Act that are designed to meet the Long Term Care needs of the elderly of this nation. Some of these provisions establish the formation of advisory panels and councils of experts to confer on the provision of mental health services to the elderly. Because Mental Health Counselors provide direct professional services to older Americans, we wish to be represented on these various panels and councils that relate to the provision of mental health services.

Thank you for the important opportunity to present our views.

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
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STATEMENT OF

AMERICAN FEDERATION OF HOME HEALTH AGENCIES

TO THE
SUBCOMMITTEE ON AGING OF THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
ON
THE OLDER AMERICANS ACT

JANUARY 31, 1984

SUBMITTED BY

JOHN G. BEARD

PRESIDENT, AMERICAN FEDERATION OF HOME
HEALTH AGENCIES

PRESIDENT, John Beard • **VICE PRESIDENT,** Joan Buddi • **SECRETARY,** Kyle Altman
TREASURER, Alan Spector • **EXECUTIVE DIRECTOR,** Morrie Levy

My name is John Beard. I am the president of the American Federation of Home Health Agencies. I am also president of Alabama Home Health Care, Inc., a home health agency in Birmingham, Alabama. I am very pleased to have this opportunity to present testimony to the subcommittee on Aging of the Senate Labor and Human Resources Committee, as members consider reauthorization of the Older Americans Act.

AFHHA is a national trade association representing both nonprofit and proprietary small business home health agencies across the United States.

AFHHA believes that the goals of the Older American Act should be at the top of our list of national priorities and we therefore urge swift action to reauthorize this legislation. The coordinated programs developed under the Older Americans Act are the key to enabling many elderly Americans to remain where they prefer to be--at home. We urge provision of funding levels adequate to support carefully targeted expansion of services to help even more vulnerable older Americans stay in their own homes. Programs authorized under this law pay dividends far beyond the rather modest outlays, by heading off institutionalization for which Medicare and Medicaid would otherwise have to pick up the tab.

The plans implemented by the Area Agencies on Aging are particularly crucial to elderly Americans because of the enormous gaps in coverage of health needs under other Federally funded programs. As a result of the exciting developments in medical technologies over the past two decades and the ability to obtain access to these technological advances at little or no out-of-pocket costs, mainly due to Medicare, most elderly live for many years after the onset of an acute illness. Today, of those 26 million who are over 65, almost 40 percent experience one or more chronic physical or mental handicaps, but Medicare is principally oriented to the reimbursement of acute illnesses. It does not pay for custodial care, which is the type of care most chronically ill patients require, and it is not geared toward maintaining people at home, which is where practically all chronically ill people wish to be.

At the same time that our aged population is undergoing a significant increase in numbers and experiencing an increase in the incidence of chronic impairments, the support system in our society has changed drastically. This latter results from a major change in the nature of the American family. Today's elderly grew up in the depression and, of necessity, had fewer children. This has resulted in fewer offspring to care for them at the very time that they are living longer and experiencing severe chronic impediments that require supportive services, but which need not be at the level of intensity normally provided in a institutional setting. Additionally, economic changes over the past 10 to 15 years have resulted in more and more wives working, further reducing the ability of families to care for their elderly members. The extensive inflation experienced over the past decade has also resulted in families occupying smaller homes and apartments, making it more difficult to take in elderly family members. The result of all of this has been that a large proportion of the elderly with chronic conditions can be maintained out of institutions if adequate support systems were available, but economic and social factors ironically reduce the availability of such systems. Programs funded under the Older Americans Act help to fill the gap here, but an even stronger commitment to home health and related services can insure that many elderly presently at risk of institutionalization will be provided needed assistance.

We are not saying that home heath services can solve all of the problems our society faces in assuring adequate care for the elderly. What we are saying is that given the aging of our population, the significant increase in the number of people with chronic conditions, the diminished support network existing now and likely to be present in the future, home health services is the treatment of choice for maintaining large numbers of the chronically impaired out of higher cost institutions and in their homes. We urge increased funding under Part B of Title III of the Older Americans Act for grants to states to help the elderly avoid institutionalization through a coordinated system of pre-institutional screening and carefully supervised home health and homemaker services.

Large numbers of the elderly could be maintained with dignity in their places of residence if they could obtain home health aide-homemaker services on a regular basis to assist them with personal needs such as dressing and bathing, or help in moving around outside the house. There are many elderly with chronic conditions such as arthritis or diabetes that cause severe functional impairments.

At present, Alzheimer's disease most often leads to nursing home placements, since it requires ongoing supportive care which Medicare does not pay for. Many individuals with these and similar conditions do not require skilled nursing services and are thus not eligible for the Medicare home health benefit, but if they were provided with home health aide-homemaker care, in many cases they would be able to remain out of institutions. Nursing supervision or evaluation of the aide services should be required as well as a patient assessment program to identify patients for whom aide services would preclude institutionalization.

Within this context, AFHHA urges the Aging Subcommittee to include in the Older Americans Act a requirement that personnel who go into a patient's home be properly trained and supervised. We believe that this can best be accomplished by mandating that these workers be in the employ of properly accredited, licensed, or Medicare-certified agencies. We fear the use of "independent contractors," who may be poorly trained or unsupervised, could lead to inadequate care or even abuses of the type that have received national publicity recently. We must insist that those who deal with our nation's elderly, and who are paid with the hard-earned dollars of the American taxpayer, adhere to strict standards of care. The well-being of our older Americans requires no less.

Thank you for this opportunity to present AFHHA's testimony to the Aging Subcommittee.

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TO: Ted Totman
Senate Special Committee on Aging

FROM: Robert Newcomer, Director
National Policy Center on Health

RE: Comments on Community Based Long-Term Care Provisions in the Older Americans Act

DATE: January 19, 1984

I am pleased to have this opportunity to give you my personal perspectives on some of the key issues facing the aging network and the possible role of this network in community-based long term care. Over the past seven years I have been involved in several studies of state and area agencies on aging, and state Medicaid and social service programs. Through this experience I have formed some perspective on the capacity and shortcomings of these administrative systems, and of the strengths and weaknesses of our current approach to long term care.

There are two general issues which I would like to address in these comments: the conceptualization of the long term care system, and the role and mission of area agencies on aging. These comments reflect my personal observations and should not be interpreted to reflect the position of the National Policy Center on Health, or the University of California.

CONCEPTUALIZATION OF THE LONG-TERM CARE SYSTEM

Long-term care, or community based long-term care, as typically conceptualized involves nursing home health care, homemaker/chore services and a variety of other community services including case management/service coordination. Usually this conceptualization does not mention the specific or general health, mental health, or functional conditions which might presumably be addressed through long-term care systems.

From my point of view, a major problem arising from this omission is a failure to recognize the interaction between acute illness, acute episodes of chronic conditions, and impairing but manageable impairments. Current health delivery and financing systems do not deal well with these dynamics either. This results because of the separation of acute care into Medicare financing, long term care (largely nursing home) into Medicaid financing, and community support services into social service funding (including Title XX and Older Americans Act resources). Needed is a financing and care management system that is capable of moving an individual from one level of care (not just services within one strata of care) to another as needs or conditions warrant.

Most of the current approaches to case management and funding integration seem designed to make more efficient use of noninstitutional long term care services, but their applicability to the acute care sector, particularly hospitals is not as evident. For example, although there have been a variety of alternative approaches to case management developed over the past few years, they largely are oriented to populations at risk of nursing home institutionalization. An assumption is made that savings from nursing home placement can be used to finance the community care services. Such an approach neglects to consider the major source of health care costs (both public and private) which is hospitals. In my view the real cost savings in having a more extensive community based care system is its potential for reducing hospital lengths of stay. Case management systems could potentially affect this through active involvement in hospital discharge planning, in addition to their current community service coordination functions.

One question which must be answered in attempting to define a role for the aging network is whether we want this role (or that of any other case management system) to be one largely designed to deflect people from institutional care (i.e., nursing homes). Such an approach is consistent with "channeling" type case management models. Interface with much more expensive care (such as hospitals) is characteristic of social health maintenance organization (SHMO) models. In my opinion premature adoption of the channeling strategy would preempt the SHMO approach and other more integrated approaches, without even bringing these up for consideration. Such a course of action seems unwise in the rapidly changing circumstances in which we find ourselves.

Important changes are indeed occurring. These include health care competition strategies through HMOs, PPOs, and various forms of prospective payments to hospitals and physicians; social HMOs; expanded private insurance coverage, and the implementation of hospital DRG's. The expected financial deficit of the Medicare trust fund, as well as the apparent cost saving success of state Medicaid contract services approaches this past year are but indicators of continuing pressure to reform the current system. Cost containment approaches placing providers at financial risk under fixed budget or with fixed rates seemingly have a real advantage at the present time -- offering both incentives for efficiency and reduced regulatory oversight. Hospitals and physician groups are the most common and likely foci for organizing and delivering services through these systems. The social HMO model is one example of this approach that is being tried in both hospital and communtiy agency auspices. A number of faculty in our Center frankly favor this general approach because it links acute and chronic care services.

The channelling based case management approach (and other variations of this model focused on populations at "risk"), while effective within limited service parameters, appears to be politically and administratively more cumbersome if it assumes responsibility across the full spectrum of acute and LTC care. At the same time, this model offers the advantage that it may prove to be more acceptable by providers and the general public as it is the least disruptive to established mechanisms of LTC care.

There is going to be substantial debate over the merits of alternative approaches, and over who controls what systems. I believe that the aging network should participate in this debate and that this participation should advocate a reasoned position for themselves. I do not believe that the network has as yet fully articulated a well defined or defensible position. The Administration on Aging (AoA) has asked our center to work with the aging network to develop alternative roles and strategies for area agencies on aging. I would like to see this reauthorization of the Older Americans Act direct HCFA to work with AoA on this task.

Role and Mission of Area Agencies on Aging

A second major issue seemingly obscured by current discussion of an expanded aging network, (especially area agency) role in long term care, is what happens to the current function, and target audience for AAAs. Do we want to abandon the traditional functions of AAAs while adopting a focus administering a long term care system? Potentially ignored if this happens are the health promotion, employment, housing, income maintenance and other community based service and advocacy activities varyingly carried out by this network. These activities address the whole elderly population -- and perhaps even represent a preventative services approach. Compounding the issue of targeted LTC services are many organizational implications of a shift in responsibilities. There are issues of auspice, administrative control over funds, management of delivery systems, client tracking, eligibility determination, quality of care monitoring, etc. On one extreme one might get the impression that AAAs are replacing the combined health and social service systems. The actual role visualized by the aging network (including the position paper adopted by the National Association of Area Agencies on Aging this past summer) is not well enough articulated to assess either its desirability or feasibility.

A further complication is the target population itself. If long term care becomes the focus of the aging network do we establish this AAA-LTC system expressly for all elderly, the low income elderly? More importantly, what happens to the MR, DD, veteran, and children populations and others needing long term care? Compounding these problems is a set of administrative issues such as the organizational placement, financing, staffing levels, cooperative agreements and other mechanisms which might make this possible. A further problem more specific to the organizational form of case management systems is whether there should be single or multiple entry points into the system. Do intakes come from the health care sector -- such as from hospital discharges, or the community? Should this be a voluntary or mandatory system for all elderly (and or non-elderly needing LTC) or only Medicaid or other income eligibles?

In short, the potential injection of the aging network into a case management or other LTC role raises important issues for discussion. My concern, however, is that a lengthy debate on these issues would be a deflection from more substantive health policy issues of today -- namely health care cost containment and health care system reform (including the provision of noninsitutional long term care). Premature adoption of an incremental suboptimizing change in the present care system, does not seem desirable at this time, and in my opinion should not be built into the Older Americans Act in 1984.

While I urge AoA and others to discuss and consider the aging network's role in LTC, I suggest that this be done in the broader context of reforming the whole delivery system. Doing this will involve interaction outside the aging network, and it runs the risk of reassessing the underlying assumptions of the Older Americans Act itself. Counterbalancing these risks is the certainty that debate about the shape of the health care -- long term care system will go on with or without the participation of AoA and the aging network.

Written Testimony of
EUGENE S. CALLENDER
Director, New York State Office for the Aging
submitted for inclusion in the hearing record of the
Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources
January 31, 1984, Hearing on Long Term Care and the Older Americans Act

This Nation faces a crisis in long term care.

As older Americans and their families seek help in caring for those with chronic conditions, they usually can't find it.

What few services they do find are often inappropriate to their particular needs, extremely expensive, fragmented, or provided only after exhausting their resources and entering poverty.

The need to reform the long term care system is clear and well documented; so is the size of the problem. In New York State alone, long term care involves billions of dollars, thousands of agencies, and millions of people of all ages and incomes.

Since 1975, New York State has implemented specific reforms designed to control the growth of institutional services, expand community-based care, and establish coordinated systems of care. These steps aim at eliminating duplication, increasing access to services, and filling gaps in available services. As this Subcommittee on Aging reauthorizes the Older Americans Act, I hope you will strengthen our ability to continue and improve on these efforts, in New York State and across the Nation.

Since 1965, Older Americans Act programs have established focal points for the elderly at Federal, State, and local levels. The Act has been pivotal in expanding both public and private resources for older people. The success of the decentralized system established under the Older Americans Act, with its increased authority at State and local levels, demands cooperation among various levels of government each operating within its own political environment. It also demands sufficient flexibility for the aging network to deal with local conditions and special needs.

The aging network in New York State has become an active participant in long term care over the past decade. Even before the 1978 amendments to the Older Americans Act, which required the network to focus on community services for older people in the greatest need, many Area Agencies on Aging were helping develop services for the chronically impaired elderly.

In New York State, we went beyond the structure of the Older Americans Act and established a State-funded Community Services for the Elderly program designed to reduce our older population's unnecessary reliance on nursing home care. Under Community Services for the Elderly, New York State required its county-based Area Agencies on Aging to coordinate planning, development, and delivery of services for frail elderly--and the State also provided both planning and services funding to help meet these responsibilities. If the national aging network is to play this role, the Federal Government must provide adequate funding for both services and administration.

Because I recognize that no single level of government can control the long term care system on its own, I convened a long term care retreat with

New York State's Area Agencies on Aging in September of 1983. The purpose of this retreat was to develop a consensus to guide the activities of the State's aging network in this critical area. Based on our three days of consultations, we have developed a draft report which is attached to my testimony. This report, which is still being reviewed by New York's Area Agencies, forms the basis for the following general recommendations which I wish to share with this Subcommittee for consideration for national implementation through the Older Americans Act:

° In its focus on long term care, Congress should reaffirm the primary goal of the Older Americans Act--the development of a comprehensive and coordinated system of services--and focus special attention on the need to develop a long term care system that is responsive to the needs of older people.

° To pursue this goal, the aging network established under the Act should make long term care a clear priority in allocating its resources at the local level. But this priority must be reflected not just in financing long term care; it must also address the need to enhance preventive services and to advocate for systematic reforms to benefit all older people.

° The network's long term care target population should consist of all older people in need of long term care, especially those with no other source of care. We must also help families who are providing care to their older relatives, and focus on services designed to maintain people in the community as long as possible and appropriate.

° Finally, the network's role in long term care should entail a Federal/State/local partnership designed to be complementary and mutually supportive. Rather than establishing a separate system of services for the frail elderly, State Units on Aging and Area Agencies on Aging should play a lead role in working with other agencies and organizations to ensure that the necessary components of a comprehensive long term care system are implemented, coordinated, and operating effectively at the local level. We should also give special emphasis to providing community education.

The aging network's ability to help reform the long term care system in this country is dependent on a strong reauthorization of the Older Americans Act which clearly sets forth State and Area Agencies' authority to do so. In implementing the general principles summarized above, several specific provisions should be included in the reauthorization to meet this goal:

1) Program Development and Coordination

This Subcommittee's focus on long term care reform through the Older Americans Act ironically contrasts with the Administration on Aging's 1982 regulatory change severely restricting the aging network's authority to play its essential role in coordinating long term care programs and developing better ones.

Although the 1981 reauthorization of the Act made substantial changes including authorizing two- to four-year plans, transfers up to 20 percent among service titles, and use of nutrition contributions for certain supportive services, the only regulation promulgated by the Administration on Aging since then--dealing with program development and coordination--imposed severe new restraints that were not based on the 1981 reauthorization and, indeed, which seem to contradict the legislative purposes of the Act.

If Congress seriously intends that the aging network play a significant role in long term care reform, these restrictions must be removed.

Under section 303(c) of the Older Americans Act, Congress specifically divided permissible use of Title III funds between Area Agency administration and services related to comprehensive and coordinated systems:

> (c) Grants made under parts B and C of this title may be used for paying part of the cost of--
> (1) the administration of area plans by area agencies on aging designated under section 305(a)(2)(A), including the preparation of area plans on aging consistent with section 306 and the evaluation of activities carried out under such plans; and
> (2) the development of comprehensive and coordinated systems for supportive services, congregate and home delivered nutrition services, the development and operation of multipurpose senior centers, and the delivery of legal services.

In making the distinction between "administration of area plans" (subject to the 8-1/2 percent limitation under section 304(d)(1) of the Act) and other permissible Title III activities (outside the 8-1/2 percent limitation), Congress specifically included "development of comprehensive and coordinated systems" under the non-administrative section. This provision reflects the priority given to systems development under the statute, a priority which is essential for the aging network in helping force long term care reform. The critical nature of this task is reflected in the draft long term care report which I have attached to this testimony.

Despite this statutory emphasis, however, the Administration on Aging issued a regulation on September 22, 1982, forbidding any Area Agency to use any services funds for program development and coordination unless all the Area Agencies in the State, taken together, spent a full 8-1/2 percent of the State's III-B and III-C services allotments for Area Plan administration. In States like New York, Area Agencies' Older Americans Act administrative charges do not reach this 8-1/2 percent figure--so, despite the statutory language, this 1982 Federal regulation forbids any

Area Agency to use services dollars to fulfill the program development and coordination priority of the Act. (The only exception I am aware of pertains to program development efforts included under the "Senior Opportunities and Services" program authorized by section 321(a)(14), as added by the 1981 reauthorization.)

If Area Agencies are to help reform the long term care system, Congress should reaffirm section 303(c) and overturn 45 CFR 1321.25(h), the 1982 regulation which severely restricts Area Agencies' ability to help reform the long term care system through program development and coordination.

To further enhance these essential activities, Congress should consider authorizing Area Agencies to use up to 5% of their services allotments--separate and apart from the 8-1/2% administrative allotment--for planning, program development, and coordination.

2) State Administration

Although Area Agencies have been bureaucratically barred from spending services dollars on program development and coordination, at least they have an administrative funding source that keeps pace with services increases. But local coordination with health, social services, and other delivery networks is impossible unless their parent State agenices coordinate their requirements. State Units on Aging, trying to represent the interests of the elderly amidst the policy and budgetary ferment of State government, have actually been awarded decreasing funds to administer growing Older Americans Act programs and to promote systematic reforms at the State level.

Over each of the past three fiscal years, funds appropriated for State activities under the Older Americans Act have been less than for Federal Fiscal Year 1981. Because the distribution formula for these funds includes substantial minimum base and hold harmless factors, large States like New York have suffered disproportionately. Despite the growth in our responsibilities, our service programs, and our elderly population, New York's basic allocation for State activities is now some $200,000 less than in fiscal 1979.

Governor Mario Cuomo has issued Executive Order 12 to assure that State policies affecting older New Yorkers are subject to review and comment by the Office for the Aging. Because of the crisis in long term care, many of these policies focus on that area. I have also made long term care reform a priority for the New York State Office for the Aging, including the long term care retreat held this fall with our Area Agencies on Aging. But with declining Federal resources, our ability to continue these efforts without harming the quality of service delivery of Older Americans Act services is in jeopardy.

Although the Reagan Administration's block grants authorize administrative expenditures up to 10% or 15%, I urge a shift in the Older Americans Act to authorize State units to spend no more than 5% of their Title III-B and III-C allotments (or the fiscal 1981 level, whichever is greatest) for State activities including administration and systems development. This shift will recognize the expansion of service programs in recent years and permit State units to expand their efforts in promoting and facilitating long term care reform.

3) Advocacy Responsibilities

If State and Area Agencies on Aging are to help reform the long term care system, they must remain free to advocate on every level where system decisions are made--Federal, State, and local. Yet recent efforts by the Office of Management and Budget to stifle political advocacy by federally funded entities contain only a minor exception for activities mandated by law.

Most Area Agencies probably believe they are required to advocate on Federal and State issues as well as local ones. Certainly they could not fulfill their responsibility to develop comprehensive and coordinated systems if they ignored higher levels of government. One cannot realistically speak about long term care reform without examining the need for changes in Medicare, Medicaid, the Social Services Block Grant, and HUD congregate housing programs, as well as the Older Americans Act. Yet the provision of the Older Americans Act mandating Area Agency advocacy, section 306(a)(6)(D), requires only that they:

> (D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect the elderly;

Similarly, the mandate for State advocacy in section 305(a)(1)(D) requires State units on aging to:

> (D) serve as an effective and visible advocate for the elderly by reviewing and commenting upon all State plans, budgets, and policies which affect the elderly . . .

To assure that State and Area Agencies remain able to advocate for long term care reforms across all levels of government, I strongly urge that their responsibilities for advocacy at Federal, State, and local efforts be specifically referenced in these sections of the Older Americans Act.

4) Single-Purpose Agencies

The Older Americans Act requires that States designate a "sole State agency" to serve as the State unit on aging under section 305(a)(1); States also designate Area Agencies on Aging under section 305(a)(2)(A). Yet, by statute, these State units and Area Agencies on Aging could be multipurpose agencies with little or no focus on elderly people. In light of the Administration on Aging's proposed regulations, which would delete the current regulatory provisisions requiring single-purpose agencies or single-purpose units within larger organizations, I recommend that the aging network be strengthened by requiring that State units and Area Agencies be single-purpose agencies which, where applicable, constitute primary bodies (equivalent to departments) of State or local government. The regulatory provision requiring a full-time director and adequate number of full- and part-time staff should also be written into law. Similarly, the U.S. Commissioner on Aging should be elevated at least to the Assistant Secretary level. Only with this primary status will their views on long term care be fully heard.

5) Training

Although I recognize that a separate hearing will be held on Title IV (training, research, and discretionary activities), I believe the connection between long term care reform and training cannot be overlooked. With substantially reduced State Education and Training grants since fiscal 1981, State units' ability to enhance the capacity of Area Agencies has been lessened. If State and Area Agencies are to play a substantial role in long term care reform, we must receive sufficient resources to enhance training and development efforts for aging network staff. The Administration's budget request for Federal Fiscal Year 1985, if enacted, would decimate these training efforts in long term care as in every other area.

In addition to providing adequate appropriations, Congress should mandate that the Administration on Aging award at least 25% of Title IV appropriations for State Education and Training grants. Initial proposals for reducing these allotments still further would have severely harmed the aging network; these proposals should not be allowed to resurface.

These comments have focused on the long term care initiatives that can be enhanced through a strong reauthorization of the Older Americans Act. I will submit additional comments pertaining to other provisions of the Act in connection with future hearings. But in closing this testimony, I must applaud the Subcommittee for focusing legislative attention on the current crisis in long term care.

If the Congress is serious about asking the aging network to play an effective role in promoting long term care reform, substantial increases in Older Americans Act funding are essential. Perhaps these increases should be focused specifically on planning and coordination responsibilities, as with the 100% State aid provided under New York State's Community Services for the Elderly program. So long as Federal funding for State activities under the Older Americans Act is static or declining, so long as funding for Area Agencies' program development and coordination efforts is restricted and insufficient, the network's ability to promote long term care reform will remain inadequate.

Unlike major funding sources such as Medicare and Medicaid, the Older Americans Act cannot provide the resources for providing most long term care services. But because of the Act's focus on system building, it can provide the impetus for genuine reform of the long term care system. I am encouraged by your interest in fulfilling this potential, and I look forward to a strong reauthorization that will strengthen the aging network's ability to meet this goal.

STATEMENT OF

HOME HEALTH SERVICES AND STAFFING ASSOCIATION

AND

NATIONAL ASSOCIATION FOR HOME CARE

PREPARED FOR THE
RECORD OF HEARING
ON

REAUTHORIZATION OF THE OLDER AMERICANS ACT

BY
SUBCOMMITTEE ON AGING
HONORABLE CHARLES E. GRASSLEY, CHAIRMAN

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON
JANUARY 31, 1984

STATEMENT OF THE
HOME HEALTH SERVICES AND STAFFING ASSOCIATON
AND THE
NATIONAL ASSOCIATION FOR HOME CARE

A. INDEPENDENT CONTRACTORS

Introduction

The Home Health Services and Staffing Association[1/] and the National Association for Home Care[2/] would like to take this opportunity to address a potentially troublesome issue for the future administration of the Older Americans Act (OAA). Our concern involves the possibility that certain individuals who provide homemaker and chore services under the OAA may be classified for tax purposes as independent contractors. To the best of our knowledge, this classification has not been utilized in connection with programs administered under the Act.

[1/] Members of the Home Health Services and Staffing Association (HHSSA) are investor-owned, tax-paying organizations, which provide both home health care services and supplemental nursing services through over [1,000] offices in [44] states. In order to be eligible for membership in the Association, an entity must assume the legal obligations of an employer with respect to the professional and nonskilled personnel utilized in providing home care services to individual patients, as well as supplemental nursing services to hospitals, nursing homes and other institutions. These obligations include the payment of FICA and FUTA taxes, workers' compensation and federal and state withholding.

[2/] The National Association for Home Care (NAHC) is the nation's largest professional organization representing the interest of over 2,000 home health agencies, hospices, and homemaker/home health aide organizations throughout the United States.

The question of proper tax status for homemakers and chore workers has arisen in the home care industry at large, as well as in the administration of certain state grant-in-aid programs for the elderly. For example, the workers in these state programs usually fail to meet the criteria for independent contractor status. Consequently, they end up being the employees of the elderly clients being served. These persons are often not capable of assuming the responsibilities of an employer, which means that legal obligation to see to tax withholding and tax payments are in fact ignored.

We are thus raising the issue simply to inform the members of this Committee of a potential problem. We would hope that any change to the OAA during its reauthorization would build in safeguards to protect against potential abuses of the independent contractor status.

Background

Traditionally, local home health agencies are awarded contracts under the OAA's Title III, "Grants for State and Community Programs on Aging", to provide essential services to the elderly with the greatest economic or social need. Among the in-home services provided through recipient agencies are those provided by homemakers and chore workers.

These workers are customarily the employees of the contractor agencies, which assume all of the legal obligations of an employer. Accordingly, the provider agencies function to assure their workers the statutory and other benefits to which they are entitled. As such, they pay the employer's share of FICA and FUTA taxes; pay premiums and provide coverage under state workers' compensation, unemployment and disability laws; withhold and report federal and state taxes; and apportion sick leave, vacation and paid holidays. In addition, the employment relationship entails the critical services component of professional supervision over the worker.

When a home health agency does not undertake the legal obligations of an employer with respect to its personnel, it usually fails to perform many if not all of the above-listed functions. This failure raises obvious problems from the standpoint of tax revenue collection. We also believe that it creates a risk of diminished quality of care for patients receiving home health services, particularly in those cases where non-professional homemakers and home health aides are treated as independent contractors.

Whether or not an employment relationship exists depends on a detailed examination of the facts of the particular situation. The principal feature of an employment relationship for tax classification purposes is the right of the person receiving the services to control the detailed manner and method by which services are performed.

When a nonskilled or semi-skilled worker -- such as a companion, sitter, home health aide or homemaker -- performs services in the home under an OAA program, either the resident or the provider agency usually exercises sufficient control to characterize the worker as an "employee" under common law tests. These workers (unlike, for example, registered nurses in certain circumstances) usually lack the training and experience required to determine and control independently the manner and method of his or her performance. Therefore, they are not appropriately classified as independent contractors.

We are concerned about this potential problem with respect to the OAA programs because of our experience in other areas. For example, the services of homemakers and chore workers are paid for by some state administered grant-in-aid programs. Usually, the governmental units administering these programs play a role in the selection, training, and supervision of the home workers.

In the past, however, incidents have arisen where such governmental units have not been willing to accept the legal role of employer, presumably because they do not wish to assume the tax withholding and related functions associated with that status (even though state governments are exempt from paying the employer's share of FICA and FUTA taxes). Since homemakers and chore workers meet few of the usual legal tests for independent contractor status, under the tax classification criteria, the worker in this situation actually becomes the employee of the program recipient -- an employment arrangement that is clearly unintended and inappropriate. We are certain that no one would advocate that program beneficiaries (often elderly, ill and poor) should keep track of income tax withholding, worker's compensation, unemployment benefits, and Social Security. Nor should these beneficiaries be deprived of supervision over home workers by the administering program agency, entailing such responsibilities as appropriate liability coverage, which necessarily derives from the agency's assumption of the obligations of an employer.

The alternative, which is to classify such homemakers and chore workers as self-employed, or independent contractors, would not only contravene existing law and regulations concerning the tax status of workers under federal and state law but similarly would deny program beneficiaries the advantage of appropriate provider supervision. This result confuses public policy and disregards employment tax laws.

For these reasons, it is important to ensure that either a governmental unit or contract services provider assume the responsibilities of the employer role in these programs. Safeguards can then be built into the employment arrangements to make certain that such workers are properly supervised and receive the necessary training to perform their tasks adequately.

B. DISCRIMINATION AGAINST CERTAIN PROVIDERS

In addition to the mutual concerns with respect to the matter of independent contractors, HHSSA would like to address an issue that deals with the state review reqirements for contracts made with proprietary organizations under the OAA's provisions for contracting and grant authority. Section 212 of the Act currently requires state agency approval of contracts made with for-profit organizations. State review is not required, however, for contracts made with non-profit organizations under the Act. This distinction requires area agencies either to contract solely with non-profit home health agencies or to justify their decision to contract with for-profit agencies. HHSSA believes that the burden of justifying the selection of a for-profit contractor functions to discourage area agencies from making these selection decisions on the basis of which home health agency can deliver the best services at the most efficient cost.

To provide for equality of treatment of all services providers, Section 212 could be amended by simply deleting the state approval requirement for proprietary organizations and permitting states to adopt non-discriminatory standards for state approval of such contracts. Consequently, a state could choose to implement a review mechanism for all contractors, for-profits and non-profits alike.

HHSSA feels that this change would ensure competition among providers of services and create incentives to deliver high-quality care at lower cost. The area agencies, functioning as the consumer, would thus have available a greater choice of providers. By eliminating this discrimination against for-profit organizations in Section 212, the Act would be administered under terms similar to the operating terms of other government programs that contract with for-profit agencies, such as Title XX of the Social Security Act.

HHSSA and NAHC would like to thank the Committee for this opportunity to express the views of our Associations during the reauthorization process of the OAA. We look forward to continuing our work with Congress on these and other important matters which affect both our organizations and those that we serve.

national
association
of regional
councils

1700 K St., N.W., Washington, D.C. 20006 • Area Code (202) 457-0710

October 7, 1983

OCT 12 1983

Hon Charles E. Grassley, Chairman
Subcommittee on Aging
Senate Committee on Labor and
Human Resources
SH-404 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Grassley:

I am writing to request an opportunity for the National Association of Regional Councils to testify before your subcommittee at hearings scheduled for November 29 and December 6 on the targeting of resources under the Older Americans Act and long-term care.

As an organization of local elected officials serving on regional agencies, NARC is keenly interested in the subject matter of these hearings. Approximately 150 regional councils serve as area agencies on aging, the majority of which are members of NARC. The targeting of scarce resources under the Older Americans Act is a natural item of interest because regional councils were formed to promote better use of local resources. I believe that our members could supply the committee with many examples of how area agencies on aging operating under the auspices of regional councils have been able to supply more efficient services and coordinate them with other programs impacting on the elderly population.

NARC would also be very interested in testifying on the issue of long-term care. Finding cost-effective alternatives to institutional care is a growing concern of local elected officials. NARC is currently putting together a task force to study this issue in greater detail and we plan to have recommendations ready by next month. It is our feeling that the provision of community-based long-term care will require many changes in the way local governments provide services in such areas as housing, transportation and health care. NARC would like to explore with the subcommittee how local governments through regional cooperation can assist in making community based care a reality for the elderly citizens of our country.

Please have your staff contact George Gaberlavage at NARC, (202) 457-0710, about the date and time of our appearance before the subcommittee. I look forward to hearing from you in the near future.

Sincerely,

Charles F. Horn

Charles F. Horn
President

cc: Pete Conroy, Staff Director

CFH/sr

Testimony of

MAGGIE TINSMAN

A Scott County, Iowa Supervisor

for the

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

"Long Term Care Under the Older Americans Act"

January 31, 1984

LONG-TERM CARE

As hearings are held on the reauthorization of the Older Americans Act, many single aging issues will be discussed. None will be as comprehensive nor complex as the issues of long-term care. No single issue will have the long-range impact on the nation's elderly as this most difficult issue.

The language of the Older Americans Act currently contains language with regard to the vulnerable elderly. Who are more "at-risk" than our elders who are inappropriately/prematurely institutionalized? The Act and subsequent regulations gave states responsibility as advocates of institutionalized older people to the extent that long-term care ombudsman programs were developed. State and Area Agencies on Aging also advocate for non-institutionalized elderly. The congregate meal program, senior citizen centers, legal services, etc. all deal with the well-being and quality of life of our seniors. What remains is a fragmented approach to an aging population with increasingly complicated needs.

In Iowa we have been reviewing the long-term care needs of our population for nearly a decade. From specific task forces have come the Iowa Gerentology Project, the development of the Title XIX Medicaid Waiver, and six model community based services projects to develop long-term care plans for the elderly.

As a Commissioner for the Iowa Commission on Aging, I have witnessed the slow acceptance of the need to develop a long-term care plan for the elderly in Iowa. Yet, inch by inch, the Iowa Commission on the Aging moves toward the development and funding of a long-term care plan. At a recent meeting of the Commissioners, we voted to request changes in the language of legislation for our state funded Elderly Services Program that would make the services more compatible to those provided under Title III of the Older Americans Act while targeting services to the vulnerable elderly. However, additional funds are still needed to deal with the individual assessments and case management of the at-risk population needing a continuum of care.

In Iowa, we have determined that nearly five percent of our elderly are institutionalized, while ten to thirteen percent are homebound and perhaps facing institutionalization. Through formal support systems, we have provided services such as homemaker-health aides, visiting nurses, chore, home maintenance, home delivered meals, and volunteers to provide such things as companionship and telephone reassurance. Families and neighbors continue to provide the informal supports for both homebound and institutionalized elderly -- the kind of support and responsiveness that is so typical of Iowans.

We have found, through our model projects in Iowa, that enhanced coordination of all local human services agencies can avoid spotty services to our at-risk elderly. These projects are borrowing from existing staff. Therefore, the projects are not only limited to serving a few elderly but are also limited to serving a small geographic area.

Important here is the fact that the basis for expansion has been developed in six of our sixteen Planning and Service Areas in Iowa. The Medicaid Waiver will initially be implemented in the same areas; but unless additional funds are provided for individual assessments and case management, we will continue to have but six very limited community based long-term care projects serving primarily low income elderly. In Iowa, we have requested approximately 1.6 million dollars from the legislature for individual assessment and case management. However, since Iowa has not felt the benefits of the "recovery", there is no chance that the Iowa legislature can possibly consider our request seriously. Rather, it will be impossible to generate full support from the state without additional support from Congress.

As I stated eariler, the issues of long-term care will be difficult to address in the reauthorization of the Older Amercians Act. Some steps have been taken to date -- the emphasis on the vulnerable elderly, long-term care ombudsman, and targeting services are all ways to deal with this issue. It has been my experience that this method does provide encouragement and some direction for states and Area Agencies on Aging. But, where there is minimal commitment to the holistic approach in serving the invisible elderly, this emphasis could be ignored. Therefore, I believe we must not only increase the emphasis of the Act and subsequent regulations in the area of long-term care, but we must also support that with increased funds from Congress. I request the funds with a heavy heart, for I agree with you about balancing the budget and no deficit financing. Yet, I ask you to reflect on the benefits to senior citizens and the resultant cost savings of long-term planning as opposed to crisis intervention and institutionalization.

What we will be legislating are choices. A long life with continued options guarantees that whatever quality of life our seniors choose, it will be their choice.

Respectfully submitted,

Maggie Tinsman

Maggie Tinsman

MT/kw

State of Iowa
Executive Department

IN THE NAME AND BY THE AUTHORITY OF THE STATE OF IOWA

PROCLAMATION

WHEREAS, *by the year 1990, almost 20 percent of all Iowans will be over 60; and*

WHEREAS, *older Iowa workers are symbolic of the dedication, drive and commitment that underlies the Iowa work ethic; and*

WHEREAS, *older Iowa workers have been and must continue to be a valuable resource upon which we can draw to ensure the quality development and growth of this state; and*

WHEREAS, *we recognize the economic and social problems that older workers cope with throughout the course of their working life; and*

WHEREAS, *it is imperative that Iowa employers remain sensitive to not only the special needs but the unique contribution older workers' greater experience and loyalty allows them to make:*

NOW, THEREFORE, I, *Terry E. Branstad, Governor of the State of Iowa, do hereby proclaim January 29 to February 4, 1984, as*

OLDER WORKERS AWARENESS WEEK

in Iowa, and encourage Iowans to express their appreciation and lend their support to Iowa's older workers.

IN TESTIMONY WHEREOF, *I have hereunto subscribed my name and caused the Great Seal of the State of Iowa to be affixed. Done at Des Moines this 26th day of January in the year of our Lord one thousand nine hundred eighty-four.*

Terry E. Branstad
Governor

ATTEST:

Mary Jane Odell
Secretary of State

GOVERNOR
TERRY E. BRANSTAD

FOR IMMEDIATE RELEASE:
January 26, 1984

CONTACT: Susan Neely
515/281-3150

DES MOINES--To draw attention to the growing number of elderly Iowans, in and out of the labor force, Governor Terry Branstad today proclaimed January 29 through February 4 as Iowa Older Workers Awareness Week.

"During this week the Department of Aging will kick-off its campaign to get Iowa employers to hire more older Iowans," Branstad said. The Department is mass mailing 3,000 bumper stickers -- "55 is the speed limit, not the age limit, hire an older Iowan" -- to agencies across Iowa.

By 1990, almost 20 percent of Iowans will be over 60. Recent studies of the labor force indicate that significant changes in the population structure are taking place:

- There is a simultaneous decline in the birth and death rates. A greater proportion of the population will soon be in the group that is now considered to be of retirement age and a lesser proportion will be in the prime working age group.
- The health of older people is improving making many persons capable and eager to continue working.
- Older persons role vis-a-vis the family has changed as more and more families are separated by distances. Many older persons are reluctant to give up the social aspects of their jobs.
- Retired people are finding it difficult to cope with inflation.
- Businesses are beginning to recognize that older workers provide a vast repository of experience and know-how which they cannot afford to lose at a time of lagging productivity.

"Iowans need to become aware of the plight of older workers," the Governor said. "With changes in technology, business, and population distribution, society has to readjust it's attitudes toward the older worker. These people are a viable force in the labor market."

Senator **Grassley**. I want to thank you all very much, and the meeting is adjourned.

[Whereupon, at 12:33 p.m., the subcommittee adjourned, subject to the call of the Chair.]

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

Title III—Grants for State and Community Programs on Aging

FRIDAY, FEBRUARY 24, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
SUBCOMMITTEE ON AGING,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:39 a.m., in room SD-430, Dirksen Senate Office Building, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

Present: Senators Grassley, Eagleton, and Pell.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator GRASSLEY. I would like to call this hearing of the Subcommittee on Aging of the Senate Committee on Labor and Human Resources to order and to thank members of the public as well as those whom we invited to testify. Thank you very much for your attendance and patience.

Today this committee continues its hearing schedule and the hearing today is related to the reauthorization of the Older Americans Act. Hopefully the Senate and the other body will stick to our schedule, which calls for the completion of legislation by the end of April, and this would allow the President, then, to sign another 3-year authorization on or before May 1, which is the beginning of older Americans month.

This morning's hearing deals with the best known title of the Older Americans Act, title III, which is entitled "Grants for State and community programs on aging." Title III enables the States and local agencies to implement the services, nutrition sites, and senior centers that have the highest profile for the Nation's elder population. As presently written, title III directs the commissioner to administer through the Administration on Aging and the States and local agencies a program that covers three crucial areas of service allowing older Americans, one, to secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services.

The second is to remove individual and social barriers to economic and personal independence for older individuals. And the third is to provide a continuum of care for the vulnerable elderly.

We on this committee will be hard pressed to improve on the original language written by far sighted legislators, many of whom still serve in this body and in the House of Representatives. This act has been one of the premier achievements of the Congress, as instituted in 1965 and in its subsequent reauthorization.

The witnesses assembled here this morning have suggestions for the Congress so that the three purposes designated in the present act may be more fully and equitably achieved. This committee looks forward to their testimony, for as serviceable and as adaptable as the Older Americans Act has proven itself to be, it may need a degree of new direction in certain areas or fine adjustment in its focus.

Our first witness is the Commissioner of the Administration on Aging and we all know Dr. Tolliver very well, so she certainly needs no introduction to this committee or to me as an individual. I want to thank you, Commissioner, for your generosity in appearing before this committee a number of times to help us in the reauthorization process and that cooperation is very much appreciated. I am reminded already that you will be back with us next week as a continuing demonstration of your efforts to help us get this hearing process completed toward reauthorization.

The Commissioner will discuss the rationale and the details of the administration's recommendations to consolidate authorization for funding of title III B and C program. The administration believes that this would increase the States' flexibility to set service priorities to meet the greatest service and nutrition needs in local areas.

I would ask you to proceed. I guess maybe before you start to talk I would make an announcement that I generally make for each witness. That would be that we would appreciate it very much if testimony would be summarized in about 7 minutes. Your entire testimony will be put in the record. I would also have you observe that other members of the subcommittee are not here now and some may not be able to come at all. And consequently we ask that if you get questions in writing from absentee members of the subcommittee that you would respond to those in about 15 days.

That would be not only for you, Dr. Tolliver, but also for other witnesses. And we would also say that the record will remain open for 15 days so that anyone who wants to add to or correct testimony can do that, and that also serves as an opportunity for witnesses or for people who were not invited to testify or we do not have time to hear their testimony, if they want to submit written testimony, as long as it is appropriate and not too voluminous, that will be included in the written record as well.

So with those precautions and administrative problems out of the way, I would ask you to proceed, Dr. Tolliver.

But before you proceed, we will enter for the record the prepared statement of Senator Kennedy.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY

Senator KENNEDY. Mr. Chairman, today's hearing addresses important aspects of title III of the Older Americans Act. Clearly, the programs of part B and C of title III, emphasized today, provide necessary supportive services to the elderly. Naturally, I am concerned about the reauthorization of title III, so that the many programs and services operating under its aegis can continue.

Of particular interest to me, however, are the programs designed to meet the nutritional needs of the elderly.

In the week before Thanksgiving in 1983, I visited five cities across this country. I found clear, undeniable, authoritative evidence of widespread and increasing hunger in America. Of particular relevance to this hearing is the finding that there is increasing hunger among the elderly.

Testimony at the forums that I conducted demonstrated that thousands of elderly Americans in many communities fail to participate in the congregate and home-delivered meals programs under the Older Americans Act because sufficient funds are not available. Waiting lists are particularly long for home-delivered meals.

In 1983, the programs served 723,000 meals per day, including 569,000 meals at congregate centers and 154,000 home-delivered meals. Testimony that I received indicated that the need for the meals was double or triple the number that could be served at present funding levels.

Participation in these senior meals programs is a lifeline for large numbers of the elderly. The two basic programs are well designed and cost effective. They insure that senior citizens receive at least one nutritious meal a day; they reduce the incidence of illness and contribute substantially to improving the quality of life for millions of retirees and their families.

Current funding for these essential programs is $384 million, an increase of only $34 million since 1981 and no increase over 1983. In the face of economic hard times and obvious need, the three Reagan budgets since 1981 have called for constant funding in 1 year and actual cutbacks of 10 percent in the other 2 years. The existing level is clearly inadequate; Congress should enact an emergency supplemental appropriation of $50 million for the current fiscal year; the new funds should be used to reduce the existing waiting lists and offset the rising cost of transportation that has become an increasing burden on local programs.

I intend to work with the members of this subcommittee and those of the full Committee on Labor and Human Resources to see if more moneys can be authorized for the congregate and home-delivered meals program.

STATEMENT OF LENNIE-MARIE P. TOLLIVER, Ph.D., COMMISSIONER ON AGING, ADMINISTRATION ON AGING, ACCOMPANIED BY M. GENE HANDELSMAN, DEPUTY COMMISSIONER, ADMINISTRATION ON AGING

Dr. **Tolliver**. Thank you, Mr. Chairman. I am pleased to be here to discuss with the Senate Committee on Labor and Human Resources Subcommittee on Aging the extension of authorization of the Older Americans Act of 1965.

I have with me Mr. M. Gene Handelsman, the Deputy Commissioner of the Administration on Aging.

I will submit a full statement for the record and will summarize the Administration's proposals for amending and extending title III of the act.

At this time, 57 State and territorial agencies on aging receive support under title III of the act. The title III activities conducted in the States are based upon 2-, 3-, or 4-year plans as provided for by the 1981 amendments. Four separate title III allocations are made to the States for State agency administration and advocacy activities, supportive services and senior center services, congregate nutrition services, and home-delivered meals. Each State makes awards to the area agencies based upon their approved area plan to pay up to 85 percent of the cost of supportive services, senior centers, and nutrition services.

In most cases, area agencies then arrange with public, nonprofit and/or proprietary service providers to deliver nutrition and other services described in the area plan. States have designated approximately 662 area agencies on aging to plan and administer the title III program. There are a total of about 10,700 persons on the staffs of area agencies, including about 2,900 older persons.

The staffs are augmented by approximately 71,100 volunteers throughout the Nation.

I would now like to report on some of the leadership and advocacy activities of the Administration on Aging. Many of the ideas and experiences gained from these activities have been used to develop the legislative package that I will share with you today.

One of the initiatives is to increase voluntary contributions from program participants. Title III regulations require that each service provider must provide each older person receiving services with a full and free opportunity to contribute toward the cost of the service.

The amount of such contributions rose from $79 million in fiscal year 1981 to $100.8 million in fiscal year 1982 and increased further to an estimated $117.3 million by the end of fiscal year 1983.

A similar initiative is aimed at improving the financial management system of State and area agencies.

An important component of this initiative is the promotion of performance based contracting as a means of reducing costs and/or increasinq services under title III; 26 States at present have agreed to promote this type of contracting. Many States use the flexibility provided under the act to employ various innovative approaches to increase productivity.

Some of these successful approaches have been the consolidation of meal sites while making appropriate provision for participants to continue receiving meals at other locations; the efficient use of USDA commodities and cash reimbursement; increasing levels of program income generated; utilization of increased numbers of volunteers; establishing strict performance criteria for service providers; training in various aspects of program management; and last, the expanded use of high technology such as computers.

I would now like to discuss major features of the Administration's proposals for amending title III of the Older Americans Act. We propose to extend for 3 years through fiscal year 1987 authorizations of appropriations for programs administered by the Department of Health and Human Services under the Older Americans Act.

In order to increase flexibility for the States in the setting of service priorities to meet the greater service needs in local areas, our proposal provides for a single, consolidated authorization of appropriations for the State grant program under title III of the act.

We propose $760,746,000 for fiscal year 1985; $781,769,000 for fiscal year 1986; and $802,414,000 for fiscal year 1987. The Administration proposes to eliminate the separate appropriation authorizations for supportive services and senior centers, congregate and home delivered meals and State plan administration under title III of the act, and to provide instead a single consolidated authorization for both administrative costs and service delivery under this program. All separate ceilings on spending for certain purposes would be eliminated and the Federal share of all program costs would be 85 percent.

Included in the consolidated authorization of appropriations for the State grant program would be an amount equal to the fiscal year 1984 appropriation for the cash or commodities meals assistance program presently administered by the Department of Agriculture under section 311(d) of the act, which would be repealed by the Administration's proposal. This proposal would allow each State to decide how much of the total Federal grant to spend on each of the above activities.

However, this is not a block grant. Unlike a block grant, States would still have to provide the services authorized in the act and give all the assurances and comply with all the program management and planning requirements of current law.

The USDA elderly feeding program began as a commodities program; however, the legislation was amended in 1977 to allow cash payments in lieu of commodities. Currently most of the reimbursements under this program are in the form of cash. In fiscal year 1983, for example, 93 percent of the reimbursements were cash. Recent estimates prepared by the Department of Agriculture indicate that a comparable rate of cash reimbursements to the States is anticipated for fiscal year 1984.

The Administration proposes to amend section 311 of the act to eliminate the requirement that the Secretary of Agriculture provide assistance to States in the form of cash or commodities for each meal served under their title III nutrition program. Provision would be made in our draft bill for an authority for the States to receive commodities.

In recognition of the continuing importance of nutrition services, the Administration's proposals would establish a new State plan requirement to help ensure that nutrition services are responsive to the needs of local communities. Each State would be required to publish before the beginning of the fiscal year its goals as to the number of meals to be served under the program and the cost per meal. The State also would be required to publish after the end of the fiscal year a statement of the actual number of meals served and the cost of those meals. In order t[illegible]ve States time to comply, this amendment would become effective with the first State fiscal year during fiscal year 1986.

The aging network has come of age and in our opinion does not require the amount of Federal direction or intervention it did 18 or even 3 years ago. The proposal is consistent with the Administration's policies to place emphasis on services to those most in need, to maintain services, and to provide for technical assistance and other support to State agencies on aging.

This proposal is consistent also with the policy to return decisionmaking to the level nearest the people. The proposals reflect existing trends of States to make extensive use of their legislative and regulatory authority to transfer funds among allotments. The Administration on Aging's experience over the last 3 years indicates that States have the ability to manage funds responsibly and will generally continue to use funds for various activities in this manner.

Mr. Chairman, this concludes my prepared remarks. This administration is deeply committed to improving the quality of life for all of this Nation's older citizens. We appreciate this opportunity to share information about some of our efforts and to present our suggestions for improving and expanding the current provisions of the Older Americans Act.

I will be happy to respond to any questions that you may have at this time.

[The prepared statement of Dr. Tolliver and responses to questions submitted by Senator Kennedy follow:]

STATEMENT BY

LENNIE-MARIE P. TOLLIVER, PH.D.
COMMISSIONER ON AGING
ADMINISTRATION ON AGING

BEFORE THE

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

FEBRUARY 24, 1984

MR. CHAIRMAN AND MEMBERS OF THE SENATE SUBCOMMITTEE ON AGING, I AM PLEASED TO BE HERE TODAY TO DISCUSS EXTENDING THE AUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965. TODAY I WOULD LIKE TO DISCUSS THE ADMINISTRATION'S PROPOSALS FOR AMENDING AND EXTENDING TITLE III OF THE ACT. THESE PROPOSALS INCLUDE EXPANDING THOSE PROVISIONS OF THE 1981 AMENDMENTS WHICH HAVE PROVIDED STATE AND AREA AGENCIES ON AGING AND FEDERALLY RECOGNIZED INDIAN TRIBES WITH THE FLEXIBILITY TO ADDRESS THE SPECIFIC NEEDS AND CONCERNS OF OLDER INDIVIDUALS IN THEIR VARIOUS JURISDICTIONS.

TITLE III OF THE ACT

UNDER TITLE III, THE ADMINISTRATION ON AGING ANNUALLY AWARDS GRANTS TO THE STATES TO FOSTER THE DEVELOPMENT OF COMPREHENSIVE AND COORDINATED SERVICE SYSTEMS TO SERVE OLDER INDIVIDUALS, TO "...(1) SECURE AND MAINTAIN MAXIMUM INDEPENDENCE AND DIGNITY IN A HOME ENVIRONMENT FOR OLDER INDIVIDUALS CAPABLE OF SELF CARE WITH APPROPRIATE SUPPORTIVE SERVICES; (2) REMOVE INDIVIDUAL AND SOCIAL BARRIERS TO ECONOMIC AND PERSONAL INDEPENDENCE FOR OLDER INDIVIDUALS; AND (3) PROVIDE A CONTINUUM OF CARE FOR THE VULNERABLE ELDERLY."

FIFTY-SEVEN STATE AND TERRITORIAL AGENCIES RECEIVE SUPPORT UNDER TITLE III OF THE ACT. THESE AGENCIES ARE ORGANIZATIONALLY LOCATED IN STATE GOVERNMENTS, TERRITORIES, AND OTHER U.S. JURISDICTIONS, EITHER AS INDEPENDENT AGENCIES REPORTING DIRECTLY TO THE GOVERNOR, OR AS COMPONENTS OF LARGER HUMAN SERVICES AGENCIES.

THE TITLE III ACTIVITIES CONDUCTED IN THE STATES ARE BASED UPON TWO, THREE, OR FOUR-YEAR PLANS, AS PROVIDED FOR BY THE 1981 AMENDMENTS. FOUR SEPARATE TITLE III ALLOCATIONS ARE MADE TO THE STATES FOR (A) STATE AGENCY ADMINISTRATIVE AND ADVOCACY ACTIVITIES; (B) SUPPORTIVE SERVICES AND SENIOR CENTER OPERATIONS; (C) CONGREGATE NUTRITION SERVICES; AND (D) HOME-DELIVERED MEALS.

EACH STATE MAKES AWARDS TO THE AREA AGENCIES, BASED UPON THEIR APPROVED AREA PLANS, TO PAY UP TO 85 PERCENT OF THE COSTS OF SUPPORTIVE SERVICES AND SENIOR CENTERS AND FOR NUTRITION SERVICES. IN MOST CASES, AREA AGENCIES THEN ARRANGE WITH PUBLIC, NONPROFIT, AND/OR PROPRIETARY SERVICE PROVIDERS TO DELIVER NUTRITION AND OTHER SERVICES DESCRIBED IN THE AREA PLAN.

STATES HAVE DESIGNATED APPROXIMATELY 662 AREA AGENCIES ON AGING TO PLAN AND ADMINISTER TITLE III PROGRAMS. AN AREA AGENCY ON AGING MAY BE A PUBLIC OR PRIVATE ORGANIZATION, AN INDIAN TRIBE, ADA has often taken the lead to advance nutrition education for older people. With ITT Continental Baking Co. we sponsored our own mini-White House conference on nutrition education when we learned that the 1981 White House conference on aging had not elevated nutrition to separate-committee status. This informal convocation involved representatives of the American Association of Retired Persons, the American Institute of Nutrition, the Food Marketing Institute, the Grocery Manufacturers of America, the Department of Agriculture, and other groups.

The result was "The Gray Paper," a series of recommendations and strategies to improve nutrition education experiences for older Americans, which was sent to all delegates to the White House conference on aging. We were pleased to see that conference recommendation No. 109 was that:

> Nutrition programs for older Americans shall include provision for nutrition education, transportation services, and recognition of special populations. This shall be done within a framework of partnership between public, private, and nonprofit sectors.

Since that time ADA representatives have met with conference staff to explore further development of the national policy on aging mandated by the 1981 conference. We also have had the opportunity to discuss issues with Dr. Tolliver at ADA's most recent conference in Anaheim, CA.

Her presentation to our group confirmed AOA's interest in working with ADA, as the previous administration under Commissioner Bob Benedict had done.

She said, "I want to express publicly AOA's appreciation to the members of the Dietetic Association and your gerontological nutrition practices group for your positive and constructive suggestions."

Encouraged by this cooperative attitude, ADA recommends that health promotion and nutrition education be an integrated, mandated, supportive service funded under part B. We also urge that the act require dietitians to plan, develop, and evaluate participative nutrition education experiences; to train others to conduct nutrition education activities; and to provide individualized nutrition counseling for participants on therapeutic diets.

We also advise that participants be involved in planning their nutrition education activities. Legislative and report language to implement these proposals is specified in the position statement on nutrition education, which is included in the written material you have.

The language proposed by ADA is similar in part to that included in Representative Ike Andrews' bill to create a new title VII so older people can learn to solve problems related to their diet, medication, mental health and other common issues.

We praise this effort because we know that many participants go home and eat nothing but tea and toast.

We need to instruct and motivate these individuals so they can fix easy, low-cost, nutrient-rich meals composed of the foods they like to eat. Dietitians can tailor nutrition education to meet the needs of older individuals, minorities, and different ethnic groups so the foods discussed match the foods they eat.

Almost 9 million people need special diets. Dietitians can help them adapt to, say, a low-sodium diet to control hypertension, and offer ideas on ingredients that are good salt substitutes in their favorite dishes; or a low-fat diet to control their weight, or a diabetic diet to control their diabetes.

In addition to working with the administration and the members of Congress, ADA identified more than 100 organizations as current or potential allies and sent them ADA's position on the reauthorization of the Older Americans Act. We personally communicate with about 30 of these organizations on a regular basis and have worked with many more on a variety of issues.

If you like, we will furnish you with a list of our contacts.

You asked us to address the needs of older people and to comment on the recommended dietary allowances for this group. Our colleague in gastroenterology will probably cover the scientific aspects of this subject. So we will present advice from our perspective as translators of the science of nutrition into practical applications.

Barriers to geriatric nutrition research include poor subject cooperation and a high incidence of chronic illness. RDA's are defined to meet the needs of healthy people and do not include nutrient requirements that may increase or change due to chronic disease or metabolic disorders or the aging process.

Dr. Hamish Munro describes the causes of malnutrition in older people as either primary or secondary. Primary causes are ignorance about diet, poverty, social isolation, physical and mental disabilities.

Secondary causes are malabsorption, alcoholism, and therapeutic drugs.

Whatever the cause, we know that 13 million older Americans have inadequate diets regardless of their incomes. That is why it is important to keep income means testing out of the Older Americans Act nutrition services, why we need to make sure that seven-day service is available through public or private means for homebound people who have no alternative but to go hungry, and why we need to reinstate the requirement that project sites serve at least five meals per week.

The present nutrient standard of one-third RDA per project meal is the best we have available now. If anything, it may be too low. Current research indicates that older individuals may need more protein and zinc if they are on medication, have a chronic illness, or are recovering from surgery.

Women need to consume much more calcium to prevent osteoporosis; hip fractures, most common in older women, cost Americans $1 billion per year. Blacks may need more B vitamins, and many older persons may need more iron and vitamin C, which helps iron absorption, to prevent anemia. Absorption of vitamin A can be reduced by laxatives and antibiotics.

A minimum intake of 1,200 calories per day is essential to obtain all these nutrients. And one-third of nutrition services participants do not even eat this much. So it is important to keep the nutrient requirements in the act at one-third of the RDA until research comes up with something better. The next RDA's will come out in June 1985, and the needs of older people are being studied. When these are published, dietitians must be available to nutrition project managers so menus and meal plans can be adapted quickly to meet the new RDA's. Project managers who employ dietitians can also expect reduction in their per-meal cost, management consultation, training for the staff and volunteers in food safety and sanitation, appropriate and appetizing meals, lively nutrition education activities, and one-on-one consultation for people with special dietary needs.

We have a lot to contribute to nutrition education in the nutrition projects. We need your help. Dietitians are not required in legislation, like the Older Americans Act and the Social Security Act, that addresses the health needs of older people in the community.

This means that many people do not have access to the level of nutrition services they need unless they are admitted to a hospital or a nursing home, where these services are mandated and can be covered by medicare. This is a ridiculous waste of money.

We urge that nutrition services be mandated in community-based, long-term care, especially home health care, to prevent expensive hospitalizations and nursing home admissions and to allow older individuals their right to good nutrition without institutionalization.

We urge you and your colleagues on the Senate Finance and House Ways and Means Committees to rectify this problem and bridge this single gap in the continuum of nutrition care.

Mr. Chairman, this concludes my testimony. I will be pleased to answer any questions you or your colleagues may have.

[The prepared statement of Ms. Greene and the ADA position statement referred to follow:]

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TESTIMONY
BEFORE THE
SUBCOMMITTEE ON AGING
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

By
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Representing The American Dietetic Association

TITLE III OF THE OLDER AMERICANS ACT
February 24, 1984
Room 430, Dirksen Senate Office Building

ADA POSITION STATEMENT ON REAUTHORIZATION OF THE OLDER AMERICANS ACT

Priority Issues: Community-Based Long-Term Care, Funding and Administration, Nutrition Education, Food Safety and Sanitation, Nutrient Standards

EXECUTIVE SUMMARY

The American Dietetic Association, representing 50,000 nutrition professionals, urges the Congress to adopt legislative and report language to prepare programs authorized under the Older Americans Act to expand and build upon significant progress made to date in keeping older individuals healthy, happy, and active in our communities. Specifically, we petition the members of Congress to:

1. Mandate that alliances be forged between the aging service network authorized in the Older Americans Act and other local service providers to integrate services into a comprehensive system of community-based long-term care. Such coordination will foster development of a continuum of care to older individuals, encourage independent living, and avoid duplication of services. Maximum cost savings can be realized when community- and home-based nutrition services provided by dietitians are reimbursed to permit greater access to nutrition services, prevent expensive facility admissions, and fill this gap in the continuum of nutrition care.
2. Take inflation, the annual rate of increase in the older population, and the proportion of older individuals at risk into account when setting authorization levels and subsequent appropriations for all Older Americans Act programs. Retain separate funding for nutrition services and supportive services so that the funding for meals, which is inadequate to serve more than one-third of the people who need them, won't be diminished in competition with other needs. Target nutrition services to older individuals at nutrition risk:

those who don't have enough money, are from minority groups, are socially isolated, are experiencing a frail old age, have chronic health problems, don't have family support, and/or can't get out of the house because of physical disability or living in a dangerous neighborhood. Half of our older population don't have adequate diets, and a good income doesn't mean that the older person eats well; so ADA does not endorse income means testing as an eligibility criterion for nutrition services.

3. Mandate a requirement for nutrition education provided by or under the supervision of a dietitian. Create a separate budget line item for nutrition education under Part B, "Supportive Services," and integrate nutrition education with other health promotion activities. Mandated nutrition education can produce significant cost savings, as evidenced by the WIC and NET programs. With adequate funding, dietitians can tailor nutrition education to meet the special needs of the older person, involve participants, increase nutrition knowledge, and improve food selection, which will result in positive health outcomes and help prevent facility admissions. Foods discussed can be matched with foods eaten by participants from different ethnic, minority, and religious groups. Nutrition education for older individuals is vital to help them cope with, for example, a sodium-restricted diet, loneliness, or money problems, and to combat nutrition misinformation.

4. Specify minimum standards for food temperature and holding times, and compliance with federal, state, and local health and safety laws and regulations. The threefold increase since 1976 in home-delivered meals exacerbates food safety problems inherent in holding hot food too long. Half of the project sites surveyed in 1981 had sanitation problems. The older population is particularly at risk when a foodborne illness is contracted, and food that is unsafe for consumption can seriously threaten their lives.

5. Reinstate the requirement that project sites serve meals providing one-third of the Recommended Dietary Allowances at least 5 days per week. Require that one project site per area provide for home-delivered meals 7 days per week, either directly or through coordination with other local services. Home-delivered meals recipients are at especially high risk of institutionalization. Some are in danger of becoming malnourished, which can lead to a weakened condition and hospitalization, or in extreme cases, even death. Additional funds are needed to provide for weekend service for people who can't prepare their own meals and have no option but to go hungry.

6. Require menu planning and meal supervision by a dietitian. This is consistent with requirements in other federal programs, such as the new Medicare hospice benefit. Project managers who employ dietitians can expect reductions in their per-meal costs, management consultation, training for staff and volunteers in food safety and sanitation, appropriate and appetizing meals, lively nutrition education activities, and one-on-one consultation for people with special dietary needs.

7. Enable AoA to take the lead role in disseminating basic and applied government research findings that could benefit the aging network. Many valuable studies are conducted by other agencies like NIA, but results are seldom widely distributed so that dietitians can interpret findings and use them in practical applications.

Five position papers, each of which provides complete rationale for ADA's position on each of its five priority issues, are available upon request from ADA. A summary of recommended legislative and report language is also available. Please contact Catherine V. Babington, R.D., or Michele Mathieu, Office of Government Affairs, The American Dietetic Association, 430 North Michigan Avenue, Chicago, IL 60611, (312) 280-5091 or -5068, for further information.

ADA POSITION STATEMENT ON REAUTHORIZATION OF THE OLDER AMERICANS ACT

Priority Issues: Community-Based Long-Term Care, Funding and Administration, Nutrition Education, Food Safety and Sanitation, Nutrient Standards

RECOMMENDED LEGISLATIVE AND REPORT LANGUAGE

The American Dietetic Association proposes the following modifications to the Older Americans Act of 1965, as amended:

- Section 101: "Declaration of Objectives for Older Americans"

  Proposed wording:

  Change (4) to read: "Health promotion and preventive services to facilitate independent living, and full restorative services for those who require institutional care."

  Add new (9): "A comprehensive, community-based long-term care system to include but not be limited to those preceding objectives listed in (1) through (8) of Section 101." Renumber existing objectives (9) and (10) (FCA, 1983).

- Section 306(a)(6)(B): "Area Plans"

  Proposed wording: "furnish appropriate technical assistance, including consultation from a qualified dietitian-nutritionist, to providers of nutrition services, supportive services or multipurpose senior centers in the planning and service area covered by the area plan. A qualified dietitian-nutritionist is an individual who is registered or eligible for registration by the Commission on Dietetic Registration of The American Dietetic Association;"

Section 307(a)(13)(F): "State Plans"

Proposed wording: "each project shall establish and administer the nutrition project with the advice of a qualified dietitian-nutritionist and other individuals knowledgeable with regards to the needs of older individuals and availability of community resources to meet these needs, and with advice from older individuals who will participate in the program;"

- Section 307(a)(13)(G): "State Plans"

Proposed wording: "each project shall utilize the services of a qualified dietitian-nutritionist to plan menus for medically prescribed special diets, supervise the preparation and serving of meals to ensure participant acceptance, and meet health requirements, religious requirements, and ethnic requirements of eligible individuals;"

- Section 307(a)(16): "State Plans"

Proposed wording: "provide, if project staff cannot supply required education and training services, assurances that area agencies shall enter into grants and contracts..."

- Section 308(b)(6): "Planning, Coordination, Evaluation, and Administration of State Plans"

Proposed wording: "Notwithstanding any other provisions of this title, with respect to funds received under subsection (a) and subsection (b) of section 303, a State may elect to transfer not more than 20 per centum of the funds appropriated for any fiscal year from programs under part B to part C of this title, and not more than 5 per centum of the funds appropriated for any fiscal year from programs under part C to part B of this title, for use as the State considers appropriate. The State shall notify the Commissioner of any such election."

- Section 321(a): (Supportive Services) "Program Authorized"

Proposed wording: "The Commissioner shall carry out a program for making grants to States under State plans approved under section 307, which include, at minimum, the following supportive services:

(1) services designed to assist older individuals to avoid institutionalization, including but not limited to:

(A) health screening, needs assessment, and referral to existing options for community-based long-term care;

(B) coordinated health promotion activities, focusing on special needs of older individuals, to enhance physical and mental well being, including:

(1) nutrition education--designed to help older individuals select and prepare foods they like to meet their nutrition needs on a limited budget--provided by or under the supervision of a qualified dietitian-nutritionist to be offered at least once a week to groups of ambulatory individuals, and at least once a month to a homebound individual;

(2) physical activity, recreation, and exercise;

(3) instruction in the safe and effective use of prescription and over-the-counter medicines;

(4) information on reducing other common risks to health, such as depression, hypertension, and stress;

(2) services designed to bridge gaps in community-based long-term care by coordinating existing services and creating new services to meet the needs of older individuals and encourage independent living, including but not limited to:

(A) transportation services to facilitate access to supportive services or nutrition services, or both;

(B) supplementation of services provided by community organizations, such as home health care agencies;

(C) services for which there is an unmet need, including:

(1) nutrition counseling provided by a qualified dietitian-nutritionist for older individuals on medically prescribed special diets; such counseling to be offered at least one day per week to an ambulatory individual, and at least one day per month to a homebound individual;

(2) shopping and homemaker services;

(D) education and training, information and referral, counseling, escort services, reader services, letter writing services, and other similar services;"

Continue with (3) and (4) in current Act; renumber (6) to become (5); renumber (9) to become (6), and continue renumbering.

. Combine Subpart 1 and Subpart 2 under Part C to read as follows:

"Part C-Congregate and Home Delivered
Nutrition Services

Program Authorized

Section 331. The Commissioner shall carry out a program for making grants to States under State plans approved under section 307 for the establishment and operation of nutrition projects for older individuals--

(1) which provide, at least 5 days per week at each congregate site, one hot or other appropriate meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council;

(2) which provide for, 7 days per week, at least one home delivered hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life) meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council."

Five position papers, each of which provides complete rationale for ADA's position on each of its five priority issues, are available upon request from ADA. An executive summary is also available. Please contact Catherine V. Babington, R.D., or Michele Mathieu, Office of Government Affairs, The American Dietetic Association, 430 North Michigan Avenue, Chicago, IL 60611, (312) 280-5091 or -5068, for further information.

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OLDER AMERICANS ACT REAUTHORIZATION

ADA POSITION STATEMENT

Issue: Community-Based Long-Term Care

A. ADA Position:

1. Forge alliances with local service providers to integrate programs authorized under the Older Americans Act into a comprehensive system of community-based long-term care. Program coordination should include but not be limited to: Medicare (Title XVIII), Medicaid (Title XIX), Social Security, Supplemental Security Income, Social Services Block Grant, ACTION programs, Community Services Block Grant, HUD Section 202 housing, Food Stamps, DOT-UMTA transportation, and VA programs (N4A, 1983). Such coordination will facilitate development of a continuum of care to older individuals, encourage independent living, and avoid duplication of services.
2. Mandate reimbursement for community and home care services provided by a qualified dietitian-nutritionist. Such services include, but are not limited to: nutrition screening, assessment, support (enteral/parenteral), counseling, education, and evaluation, management consultation, food service supervision, and menu planning. This would allow

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older individuals greater access to nutrition services, prevent expensive facility admissions, and complete the continuum of nutrition care. Until this concept of "a continuum of care" is fully operational and community nutrition services can be facilitated through reimbursement, maximum cost savings cannot be realized.

B. Proposed Modifications to the Act: (in chronological order)

Section 101, "Declaration of Objectives for Older Americans"

Proposed wording:

Change (4) to read: "Health promotion and preventive services to facilitate independent living, and full restorative services for those who require institutional care."

Add new (9): "A comprehensive, community-based long-term care system to include but not be limited to those preceding objectives listed in (1) through (8) of Section 101." Renumber existing objectives (9) and (10) (FCA, 1983).

C. Position Rationale:

For years, long-term care has immediately brought to mind visions of nursing homes or other facilities for the chronically ill or disabled, usually older, individual. The recent escalation in the cost of health care, the immense demand for nursing home care, the anticipated shortage of such care when the "baby boom" generation becomes the biggest geriatric population ever, the increasing desire of older people to remain independent--all have led to a growing awareness of and demand for services provided in noninstitutional settings.

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The primary objective of Title III of the Older Americans Act is the development of comprehensive and coordinated community-based health and social service systems to foster independent living among older Americans. Services provided by Title III to meet this objective include congregate and home-delivered meals, information and referral, outreach, transportation, legal guidance, employment information, escort, counseling, adult day care, education, home health care, and homemaker support.

Several definitions have been proposed for community-based long-term care. One that was included in a 1982 California law (A.B. 2860) is brief: "A coordinated continuum of diagnostic, therapeutic, rehabilitative, supportive, and maintenance services that address the health, social, and personal care needs of individuals who have restricted self-care capabilities" (Monteith, 1983b).

Nutrition is a critical component of community care. A continuum of nutrition care (see figure) provides nutrition services targeted to individual needs, so that people are neither under- or overserved. Assessing a person's needs and providing the correct level of service allows the best use of funds and discourages dependence on services that are not required. This is particularly important when an individual is considered for home-delivered nutrition services, as unwarranted home delivery may isolate an individual. This could decrease the effectiveness of the Title IIIc program by providing a disincentive to remain active in the community.

The continuum begins with an individual who is healthy, independent, and has enough social contact. When decreased physical strength, breakdown in social contact, and/or financial constraints begin to affect motivation, or the ability to shop and prepare nutritious meals, the person enters the community care continuum. Such an individual will gradually begin substituting convenience foods, or omitting food preparation altogether, leading to the "tea and toast syndrome" if intervention does not occur.

Participation in congregate meal service is an appropriate form of nutrition care for an individual at this stage of the continuum. At least one-third of the RDA is provided through one hot meal. Socializing and nutrition education activities can provide the motivation necessary to prepare other meals.

The strain of stretching a fixed income is also reduced by the congregate meal, as it is provided with only a request for a contribution. Individuals who are unable to pay for food, either that day or on a permanent basis, still have a source of nutrients. Those with severe financial constraints can be assisted to obtain food stamps or another income supplement. For every individual with a limited income, nutrition education can be a powerful tool to teach people how to make the most out of their food dollar.

As people become more frail, limited access to food shopping or inability to carry groceries may become a major factor in obtaining enough food. Individuals who live in inner city areas may not be able to take the bus to get to food stores that have a wide selection of fresh foods at a reasonable cost. They become dependent on small corner grocery stores that have high prices and limited selection. Individuals in a rural area may no longer be able to maintain gardens or animals that previously provided a source of fresh meat, fruit, and vegetables. A combination of transportation services to ensure participation in congregate meals and transportation to and assistance with food shopping can help these people stay in the community.

When physical or mild mental impairments eliminate ability to food shop, the individual can be encouraged to attend congregate meals to prevent isolation. Food shopping services or delivery of basic food supplies on a regular schedule can serve to provide food for other meals. These services can be organized through a Title III congregate program, a volunteer organization such as a church group, or cooperation of a food store and volunteer coordinators.

Most people can live on their own if provided with one meal, as long as they can obtain adequate food for the remaining meals. If a community-based health care network is to succeed, programs that operate only on weekdays need to find a mechanism to ensure weekend meals for people who have no other source of food. Some individuals may require a combination of congregate meals and frozen, chilled, or shelf-stable foods that can be taken home. Some participants may require food supplies for all meals and coordination with volunteers or neighbors to ensure intake beyond the one meal delivered.

When physical or mental health prevents an individual from participating in congregate meals, home-delivered meals can be furnished by Title IIIc or Meals-on-Wheels.

Significant cost savings can be realized through assessment and provision of the proper level of service. Not all participants require hot meal delivery. An individual may still be able to prepare basic food items if provided with nutrition education on safe and easy meal preparation and motivation to maintain intake at home. Individuals who can safely reheat foods in a toaster oven may be able to receive a combination of prepared frozen and shelf-stable foods every two weeks or once a month, depending on freezer space. Chilled prepared food items allow alternate day or every third day delivery. A home health aide can assist in meal preparation.

Limited socialization can be a major obstacle to adequate intake but should not be treated with daily delivery. Volunteer or paid drivers do not have enough time to chat with everybody without endangering the food safety and quality of other meals on their route. Instead, programs like friendly visitors or telephone assurance, offered by churches or other local groups, can provide needed social contact and "checkup" service.

When an individual can no longer safely heat foods, hot delivery of one meal with cold meal packages may allow an individual to remain in the community. Coordination with family, neighbors, volunteers, and/or home health aides may provide adequate supervision. Adult day care programs are another alternative to institutionalization. These programs can also be used on an occasional basis to provide a much needed break for family, friends, or other caregivers.

When severe physical or mental debilitation occurs, hospice programs furnish dietary counseling. Unfortunately, dietitians in the home health setting are not reimbursed by Medicare, so very few agencies can afford R.D. home visits. Instead, most dietitians employed by home health agencies teach nurses and aides how to cope with complex nutrition problems.

The federal government has taken some initial steps to facilitate community-based long-term care. For example, the Omnibus Reconciliation Act of 1980 encouraged utilization of home health care under Part A of Medicare, and the Omnibus Reconciliation Act of 1981 allowed states to apply for waivers of certain Medicaid requirements if home and community-based services were offered. Forty-six states have applied for 100 waivers, and 45 requests from 34 states were approved as of the middle of 1983 (Matula, 1983; Tolliver, 1983). The popularity of these waivers can be explained by a glance at this table of the national average cost per patient services, prepared by the National Association for Home Care from 1982 Medicaid data:

Skilled nursing facility	$7,854
Intermediate care facility	$6,395
Inpatient hospitals	$2,179
Home health agencies	$1,251

Another cost comparison: in 1980 the average cost to Medicare of a day in the hospital was $208, but for a skilled nursing visit, the cost was only $29.55 (HHSSA, 1983).

It is anticipated that demand for and utilization of home health care will increase. The prospective payment system now in place for Medicare inpatients will likely be extended to skilled nursing facilities this year, and to all third-party payers in the near future. The diagnosis-related group based system rewards providers financially for early discharges. Speeding discharges from facilities, preventing admissions to institutions, and serving chronically disabled persons are goals of home health care (HHSSA, 1983), and the system will need to expand rapidly to keep up with the already evident shift from inpatient to outpatient and community care settings.

Since cost is a motivating factor, employing a dietitian to work in the community prevents expensive health care costs. Examples of such cost savings include:

- Reducing need for rehospitalization because of malnutrition (e.g., oncology patient), uncontrolled diabetes, and so forth.
- Preventing fractures due to disorientation or weakness related to malnutrition.
- Delaying kidney dialysis treatment.
- Preventing food poisoning from improper food sanitation.
- Permitting earlier discharge of patients with parenteral or enteral feedings (especially where difficult home environments prohibit proper care).
- Assisting the individual to understand and use new technologies, such as enteral nutrition "home kits" and home equipment, thus preventing or delaying reinstitutionalization.

- Hastening healing of postoperative patients.
- Using a trained professional who is more efficient and accurate in the adjustment and readjustment of individualized diets (ADA, 1982b).

Federal laws and regulations permit Medicare coverage of nutrition services provided by dietitians in hospitals, skilled nursing facilities, intermediate care facilities, end-stage renal disease hemodialysis centers, and hospice programs. But Medicare payment for dietitians in home health agencies is noticeably absent, thus disrupting the availability of nutrition services in the continuum of care. Home health agencies that employ dietitians must scrape funding for nutrition services from the bottom of an increasingly limited pot of money, including Social Services Block Grant (Title XX) and Older Americans Act funds. We urge that nutrition services be mandated in community-based long-term care, especially home health care, to prevent expensive hospitalizations and nursing home admissions and to allow older individuals their right to good nutrition without institutionalization.

Continuum of Nutrition Care for Older Americans

Community-Based Long-Term Care

Obstacle to Adequate Intake	Nutrition Service
Lack of socialization, motivation, income, or physical strength to prepare meals	Congregate nutrition program (1 hot lunch 5-7 days)
	Nutrition education: importance of nutrition; motivational activities; easy, inexpensive, and nutritious meals; special requirements (e.g., low sodium, ethnic)
Limited income	Congregate meals + Food Stamps or other income supplement
	Congregate meals + nutrition education: increasing food purchasing power, low-cost and nutritious meals
Limited access to food stores, inability to carry groceries	Congregate meals + transportation (with assistance) to food store
Physical inability to food shop	Congregate meals + food shopping services
	Congregate meals + delivery of basic food supplies every two weeks
Inability to participate in congregate nutrition program, limited ability to prepare foods; can reheat foods	Home delivery of prepared frozen or shelf-stable foods every two weeks or once a month
	Nutrition education: maintaining intake at home
	Home health aide for meal preparation
	Home delivery of chilled prepared foods every 2-3 days
Limited socialization	Telephone assurance, friendly visitors, or equivalent program
Inability to safely prepare foods	Home-delivered nutrition services: hot, daily delivery of 1 meal; provision of ready-to-eat food for remainder of meals or home health aide/neighbor/family assistance
	Nutrition education for family/caregivers
	Adult day care programs with nutrition services
Severe physical or mental debilitation	Home health aide assistance with feeding
	Nutrition education for family/caregivers
	Hospice care including dietary counseling

Institutionalization

OLDER AMERICANS ACT REAUTHORIZATION

ADA POSITION STATEMENT

Issue: Funding and Administration

A. ADA Position:

1. Take the following factors into account when determining authorization levels and subsequent appropriations for all programs provided under the Older Americans Act, especially nutrition services and supportive services:

    a. At minimum, the increase in the annual market basket index or the increase in annual food costs (for nutrition services), whichever is greater;

    b. More equitable would be a funding formula that includes factors for inflation and the annual rate of increase in the older population;

    c. Most fair would be a formula that considers points (a) and (b), and adds dollars based on the proportion of older individuals at risk.

2. Target nutrition services to older individuals at nutrition risk. Factors that place an individual at nutrition risk include: inadequate income, minority status, social isolation, frail old age, chronic health problems, lack of family support, and inability to get out of the house due to physical disabili-

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ties or neighborhood safety concerns. Inadequate diets and malnutrition cut across all social strata in the older population; therefore, ADA is opposed to income means testing for nutrition service eligibility.

3. Keep funding for nutrition services and supportive services separate; establish a separate nutrition education line item, integrate nutrition education with health promotion, and fund health promotion and nutrition education as supportive services.
4. Continue DHHS funding on an annual grant basis; continue USDA administration of commodities, with the cash-in-lieu option.
5. Encourage transfer of funds from congregate to home-delivered meals to meet the growing demand, but allow only a 5 percent transfer from nutrition services to other services.
6. Establish a standardized food cost accounting system as a management tool for cost evaluation and containment.
7. Enable AoA to take the lead role in dissemination of basic and applied government research findings that could benefit the aging network.

B. Proposed Modifications to the Act: (in chronological order)

. Section 308(b)(6), "Planning, Coordination, Evaluation, and Administration of State Plans"

Proposed wording: "Notwithstanding any other provisions of this title, with respect to funds received under subsection (a) and subsection (b) of section 303, a State may elect to transfer not more than 20 per centum of the funds appropriated for any fiscal year from programs under part B to part C of this title, and not more than 5 per centum of the funds appropriated for any fiscal year from programs under part C to part B of this title, for use as the State considers appropriate. The State shall notify the Commissioner of any such election."

C. Position Rationale

Our rapidly aging population is bringing issues into focus as never before. The landmark "Social Security Act Amendments of 1983" split the burden of saving the system between retirees and employees, and introduced the Medicare prospective payment system. Recommendations by the Advisory Council on Social Security to save Medicare from going broke try to "split the pain" between all participants in the system--facilities, health professionals, employees, and beneficiaries. Such actions would have been unthinkable only a few years ago.

Today, members of Congress have to deal with constituencies that don't want their programs cut, but aren't willing or able to foot the bill. The older Americans of this country are a notable exception. They have begun to bear their share--and some would say more than their fair share--of the benefit cuts already. As a result of legislation enacted between January 1981 and July 1983, programs that affect older individuals will have been reduced in growth by $64.5 billion by 1985 (CBO, 1983). People with cash income of less than $10,000 are bearing the brunt of these cuts, which cumulative through this year will average $430 per household. In 1981, 29.5 percent of older families had cash income of less than $10,000. However, more than three-fourths of older individuals living alone made less than $10,000 (Census Bureau, 1981).

The two big-ticket entitlement programs--Social Security and Medicare--benefit all older Americans, not just those who are economically or otherwise vulnerable. These benefits can be substantial: in 1983, Medicare spent an average of $1,827 per elderly beneficiary--$5,770 per user of both Part A and Part B services (Rubin, 1983). And the average 1982 Social Security benefit for men was $5,160. But we must not forget that people who are truly needy are served by these programs, too:

- Sixty percent rely primarily on Social Security for income (Pepper, 1983).
- Women, who comprise 60 percent of the older population, fare the worst. Older women are the poorest: half of all women 65 and over had income of less than $4,757 in 1981, when the median income for older men was $8,173. Most older women live alone, and in 1982, 60 percent of them had to live on their Social Security, which averaged $3,696 for the year (Garland, 1983).
- One-fourth of black retirees depend entirely on Social Security for subsistence (Coleman, 1983).

We have heard the arguments for reductions in programs benefiting older individuals that point to the recent decline in the poverty level for this group and to the positive, macroeconomic effects of tax cuts and lower inflation. There are problems with this defense. First, the "poverty level" index is based on 1964 data, when poor people spent one-third of their income on food. Today, with the high cost of housing and utilities, the most recent survey shows that only one-fifth of poor people's money is spent on food. Using these data would bring the poverty level closer to the Bureau of Labor Statistics' income threshhold for a "lower standard of living": $15,323 per family in 1981 (O'Hare, 1983).

Second, it is postulated that the decline in the poverty rate for older people was due to a reduced effect of unemployment, since many are retirees. For those that work, unemployment increased 63 percent in less than two years (April 1981 to January 1983) for persons 55 and older (Kerschner, 1983). For those who can't work, the tax cuts only benefit them indirectly by stimulating the economy and reducing inflation.

In the Older Americans Act reauthorization, it is important to consider the future needs of older individuals. In six years, 12.6 percent of our population will be 65 or older. The over-75 group will increase more than four times faster than the under-65 group. In nine years, the number of veterans over 65 will more than double, and in 14 years the number of veterans over 75 will quadruple. The older population will continue to grow at a phenomenal rate until the middle of the next century.

Scientific and technologic advances have made it possible for more people to reach a healthy old age. Now, our job is to ensure that every opportunity is open so they can continue to contribute as members of the paid or volunteer work force, remain independent, and stay healthy. The Older Americans Act provides a wealth of incentives in this area. It benefits all of us by keeping older people vital and working in our community. How many millions of people would have to be in nursing homes if the home health network were not expanding to meet their needs? How many would succumb to their chronic illnesses if they didn't have a place to meet and help people? How many would starve if they couldn't have that one meal a day?

Some of these data—such as figures that will prove the cost effectiveness of home health care—are beginning to emerge. Medicare program statistics for 1981—after the Omnibus Reconciliation Act of 1980 provided incentives to use home health care—showed a net decrease of 7.7 persons served per thousand enrolled, including a 4 percent decrease in nursing home utilization (HCFA, 1983). We have a long way to go, though, before we can begin to serve the 4.9 million people who need help to eat, shop, fix meals, and other activities necessary to daily life (Feller, 1983). Prospective payment will mean earlier discharges from facilities, and the demand for home health care will increase.

Nutrition services provided under the Older Americans Act are a cost-effective means of keeping older individuals out of hospitals and nursing homes. Since there will never be enough money to provide for everybody, it was encouraging to note in the Kirschner/ORC report that 96 percent of all home-delivered meal participants and 78 percent of all congregate meal participants were from priority target groups, and that 75 percent live on less than $10,000 a year.

We can still do better. In California, for example, nutrition services can be provided to a mere 12.3 percent of eligibles, and 8,669 people who asked for home-delivered meal service had to be turned away last year (Shumway, 1983; Meeks, 1983). Testimony at hearings conducted last year by Senator Ted Kennedy (D-MA) "indicated that the need for (congregate and home-delivered) meals was double or triple the number that could be served at present funding levels" (Kennedy, 1983). Results from the survey fielded by the House Select Committee on Aging should help pinpoint the severity of unmet need. Meanwhile, we do know that the demand for home-delivered meals is rising rapidly, and that we will have to be "leaner and meaner" to meet this need given current resource limitations. "Doubling up" on services can help: a dietitian in Texas writes that drivers who transport older individuals and meals are trained in providing information and referral services (Griffith, 1983).

Dietitians can take some credit for recent management improvements and productivity increases that have allowed more meals to be served for the same amount of money. For example, California area agencies with adequate nutrition consultation saved 17 to 23 cents per meal, which could provide up to 146,000 extra meals per year (Livingston). And we give a lot of credit to the older individuals who are able to contribute to the cost of the meal or who volunteer their time so that more meals can be served.

We can't afford to be penny-wise and pound-foolish these days. If Older Americans Act appropriations are inadequate to maintain the current level of service, and more pressure is placed on state and local networks, older people will suffer. Pressure for increased participant contributions will likely drive away those who can't afford it--mainly minority individuals, a priority target group. Without adequate funds, State Units and Area Agencies on Aging cannot hope to develop and utilize assessment criteria to reach the most vulnerable people and attempt to provide case management services. If there is less money for project staff and services provided by qualified dietitians and food service managers, meals served will be less economical, less nutritious, and less appetizing, and incidences of foodborne illness could increase.

While improved targeting would make the best use of scarce resources, care must be taken so that legislative language is not interpreted as restricting access to services for certain groups of individuals. We agree with N4A that specifying the goal of the Older Americans Act will define the target groups: "If our goal is to offer a range of community-based and in-home long-term care services, our targeted population would be an older, functionally impaired, often female, often minority, and often low-income population. This would be far different if our goal was to provide opportunities for older people to remain healthy and active" (Moran, 1983).

ADA also believes, as does NASUA, that "emphasis must be placed on the provision of health and social services to those older persons who are most vulnerable," and that "the system should not require any income means testing because income alone is not an adequate measure of vulnerability among the elderly" (NASUA, 1983). Eligibility requirements based on income are not applicable to an older population because the physiological aging processes, concurrent nutritional problems, and social consequences of aging span all income groups.

ADA suggests targeting to groups with factors that place them "at risk;" for Title IIIc funds, targeting to groups "at nutrition risk" would be appropriate. An individual at nutrition risk is in danger of becoming malnourished, which can lead to a weakened condition and hospitalization, or in extreme cases, even death. Factors that place an individual at nutrition risk include: inadequate income, minority status, social isolation, frail old age, chronic health problems, lack of family support, and inability to get out of the house due to physical disabilities or neighborhood safety concerns. This indicates that current targeting efforts are good, but that the priority categories could be expanded.

If a priority system is required to allocate limited resources, a system that classifies individuals according to nutrition risk, such as that used in the WIC program, may be appropriate. Lower-priority target groups could receive referrals to other sites or alternate sources of nutrition services. Because the program cannot meet the needs of all older individuals, regular communication of unmet needs to other community agencies can facilitate combined efforts to meet these needs.

Better targeting to reach more minority individuals is an ongoing concern. The experience of dietitians working in congregate meal programs confirms the findings in the Kirschner/ORC (1983) report: Put the sites where minority groups live, recruit project volunteers and staff from the area, and minority participation will follow. However, ADA does not recommend opening new sites until existing sites can be brought to full capacity. Our first priority is funding to ensure that current sites will serve at least five meals per week, and that seven-day service is available to homebound p[illegible]ipants in each area.

Every program authorized in the Older Americans Act is interdependent upon the others. Without Title V staff, 25 percent of sites would have to close (Kerschner, 1983). Without Title IIIb, 9 million people might not know where to go for help when they need a doctor, transportation to go shopping, or some human companionship. Title IV projects are important testing grounds for better, more cost-effective services based on sound research and demonstration techniques. And none of these services could be coordinated without the support of the total aging network, which is provided for in Titles II and III.

ADA agrees with FCA's policy recommendations and legislative language to strengthen the research and development, demonstration, education and training role of AoA under Title IV of the Act. We especially endorse the FCA language, "Appropriate provisions for the dissemination of resulting information shall be a requirement for all grants under this Title." Although it is not in AoA's purview to conduct basic research on nutrient needs of older individuals, we advocate AoA taking the lead role in dissemination of findings from basic research, such as that conducted by the National Institute on Aging (NIH), when application of such results would prove beneficial to the aging network. The FCA provision for "technical assistance and cooperation" of NIE, NIH, etc. should enhance AoA's capabilities to disseminate findings from all relevant government-sponsored research.

Potential cost savings could be realized through investigation of, for example, the level of service required for individuals at all stages of the nutrition care continuum. When an individual is receiving services beyond that which he/she requires, an alternative—which would still meet nutritional needs, but at a lower cost—could be provided. This concept was demonstrated in the

South Middlesex Opportunity Council project, in which the type of meal delivery for home-delivered meals was based on a needs assessment. Those individuals who required home-delivered meals, but were able to prepare simple meals with no assistance, were provided with an alternate food package that did not require daily delivery. When health or safety concerns prevented food preparation, daily delivery of a hot meal was provided (Osteraas et al., 1983).

Other research investigations with potential for increasing cost effectiveness include: development and evaluation of nutrition education strategies tailored for older adults, incentives and methods to increase services to hard-to-reach older individuals, methods to integrate nutrition services into existing community services for older people, and impact of nutrition service delivery mechanisms on nutrient content and participant acceptance of meals. Demonstration projects to evaluate the cost effectiveness of new technology—such as microcomputers and software to analyze menus, perform food cost accounting functions, and control inventory—can lead the way so the tools of the aging network can keep pace with the growth of its constituency.

OLDER AMERICANS ACT REAUTHORIZATION

ADA POSITION STATEMENT

Issue: Nutrition Education

A. **ADA Position:**

1. Mandate nutrition education in the Act.
2. Fund nutrition education as a separate line item under Part B, Supportive Services, and integrate nutrition education with health promotion.
3. Require qualified dietitian-nutritionists to plan, develop, and evaluate participative nutrition education experiences; to train others to conduct nutrition education activities; and to provide individualized nutrition counseling for participants on therapeutic diets.
4. Involve participants in planning nutrition education activities.

B. **Proposed Modifications to the Act:** (in chronological order)

. Section 306(a)(6)(B), "Area Plans"

Proposed wording: "furnish appropriate technical assistance, including consultation from a qualified dietitian-nutritionist, to providers of nutrition services, supportive services or multipurpose senior centers in the planning and service area covered by the area plan. A qualified dietitian-nutritionist

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approved by BOD

is an individual who is registered or eligible for registration by the Commission on Dietetic Registration of The American Dietetic Association;"

- Section 307(a)(13)(F), "State Plans"

  Proposed wording: "each project shall establish and administer the nutrition project with the advice of a qualified dietitian-nutritionist and other individuals knowledgeable with regards to the needs of older individuals and availability of community resources to meet these needs, and with advice from older individuals who will participate in the program;"

- Section 307(a)(16), "State Plans"

  Proposed wording: "provide, if project staff cannot supply required education and training services, assurances that area agencies shall enter into grants and contracts..."

OPTION #1 (PREFERRED)

- Section 321(a), (Supportive Services) "Program Authorized"

  Proposed wording: "The Commissioner shall carry out a program for making grants to States under State plans approved under section 307, which include, at minimum, the following supportive services:

(1) services designed to assist older individuals to avoid institutionalization, including but not limited to:

(A) health screening, needs assessment, and referral to existing options for community-based long-term care;

(B) coordinated health promotion activities, focusing on special needs of older individuals, to enhance physical and mental well being, including:

(1) nutrition education--designed to help older individuals select and prepare foods they like to meet their nutrition needs on a limited budget--provided by or under the supervision of a qualified dietitian-nutritionist (an individual who is registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association), to be offered at least once a week to groups of ambulatory individuals, and at least once a month to a homebound individual;

(2) physical activity, recreation, and exercise;

(3) instruction in the safe and effective use of prescription and over-the-counter medicines;

(4) information on reducing other common risks to health, such as depression, hypertension, and stress;

(2) services designed to bridge gaps in community-based long-term care by coordinating existing services and creating new services to meet the needs of older individuals and encourage independent living, including but not limited to:

(A) transportation services to facilitate access to supportive services or nutrition services, or both;

(B) supplementation of services provided by community organizations, such as home health care agencies;

(C) services for which there is an unmet need, including:

(1) nutrition counseling provided by a qualified dietitian-nutritionist for older individuals on medically prescribed special diets; such counseling to be offered at least one day per week to an ambulatory individual, and at least one day per month to a homebound individual;

(2) shopping and homemaker services;

(D) education and training, information and referral, counseling, escort services, reader services, letter writing services, and other similar services;"

Continue with (3) and (4) in current Act; renumber (6) to become (5); renumber (9) to become (6), and continue renumbering.

OPTION #2 (ACCEPTABLE)

. Combine Subpart 1 and Subpart 2 under Part C to read as follows:

"Part C-Congregate and Home Delivered
Nutrition Services
Program Authorized

Section 331. "The Commissioner shall carry out a program for making grants to States under State plans approved under section 307 for the establishment and operation of nutrition projects for older individuals--

(1) which provide, at least 5 days per week at each congregate site, one hot or other appropriate meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council;

(2) which provide for, 7 days per week, at least one home delivered hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life) meal per day and any additional meals which the recipient of a grant or contract under this

subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council.

(3) which provide, at least one day per week at each congregate site, nutrition education provided by or under the supervision of a qualified dietitian-nutritionist. A qualified dietitian-nutritionist is an individual who is registered or eligible for registration by the Commission on Dietetic Registration of The American Dietetic Association.

(4) which provide, at least upon participant enrollment in the home delivered meals program and at regular intervals not to exceed one month, nutrition education provided by or under the supervision of a qualified dietitian-nutritionist.

(5) which provide, at least one day per week for congregate participants on medically prescribed special diets, and at least one contact per month for home delivered meals participants on medically prescribed special diets, individual nutrition counseling provided by a qualified dietitian-nutritionist."

C. Position Rationale

Nutrition education is the process by which beliefs, attitudes, environmental influences, and understanding about food lead to practices that are scientifically sound, practical, and consistent with individual needs and available food resources (Baird and Sylvester, 1983).

Since diet is implicated in six of the ten leading killer diseases (Task Force, 1979), and since nutrition plays a role in treatment of four of the most prevalent chronic conditions of the elderly--cardiovascular diseases, cancer, hypertension, and diabetes (Kohrs, 1983; Ross Labs, 1979), the importance of health and nutrition education for the older individual cannot be overstated. The cost-beneficial effect of widespread health and nutrition education is illustrated by the recent 42 percent decline in stroke deaths and 25 percent decline in heart attack deaths as the public has become aware of the roles of sodium, fat, and cholesterol (McGinnis, 1983).

The recent study funded by the Administration on Aging, An Evaluation of the Nutrition Services for the Elderly, (Kirschner/ORC, 1983) contains an error in its "Executive Summary" (Volume I): "Nutrition education activities offered by meal sites have no discernible impact upon participants' dietary intakes away from the site." This finding is totally unsupported by any data in the body of the report.

In Appendix V, "Dietary Intake Discriminant Function Analyses for Congregate Participants," the researchers found modest correlations between intake and the fact that a participant ate the meal, thought it tasted good, had a higher income, and was able to clean and maintain his/her home. These results are similar to those from a study in which socioeconomic status and nutrition knowledge were determined to be the key independent variables influencing intake (Grotkowski and Sims, 1978). Further, findings from the latter study supported the paradigm: nutrition knowledge → attitude modification → improved intake.

Nutritional adequacy of the diets was highly related to socio-economic status and self-evaluation of nutrition knowledge (attitude).

The Kirschner/ORC report states that participants' dietary intakes away from the meal site are no better than those of non-participants. Since 75 percent of participants have incomes of less than $10,000, this is not surprising. But it cannot be extrapolated to mean the converse, i.e., that nutrition education does not have an impact on intake. Using this brand of logic, a case could be made for the positive impact of nutrition education, based on another reported finding: that former participants did not have reduced intake. Thus, research is still needed to measure the effects of nutrition education on participants, taking income and intervening variables, such as attitude toward nutrition, into account.

However, current data upon which to base an objective measurement of the effects of nutrition education are inadequate. This information deficit is caused by at least two problems:

- Low participant awareness of and participation in nutrition education—not surprising when you consider that nearly three-fourths of the sites scheduled nutrition education only once a month or less. In turn, nutrition education sessions can be offered only sporadically because they have no budget and qualified staff are not required to be available.

- Widespread use of nutrition information, such as lectures or handouts, vs. nutrition education, which attempts to involve the participant and change behavior (e.g., personal counseling, games).

We agree wholeheartedly with the recommendations of the site managers surveyed by Kirschner/ORC: that nutrition education needs to be provided more frequently, that more active approaches such as games and demonstrations are needed, that there is a need for better-qualified personnel, and that more individualized approaches to nutrition education are needed. To implement these recommendations, the following objectives must be met:

1. Mandate nutrition education in the Act. Since 1976, the percentage of sites offering "nutrition education"--more likely, nutrition information--has declined. When nutrition education has been mandated in federal nutrition programs, the results have been spectacular in terms of cost savings and improved health status. For example:

a. In the Special Supplemental Food Program for Women, Infants, and Children (WIC), nutrition and health education are integrated with nutrition supplementation and preventive health care. As a result, low birth weight--which is linked to infant mortality, birth defects, and mental retardation--is reduced. So for a cost of up to $450 per pregnancy, WIC saves either: $450 per day, the cost of hospitalizing a premature infant with no complications; or $40,000 per case, the cost of extended neonatal care for an infant with complications; or $3 million per case, the cost of lifetime care for an infant born mentally retarded (ADA, 1982; Michigan, 1983; Mayer, 1983).

b. Even the low-budget Nutrition Education and Training (NET) program for schoolchildren produces results: in California, NET participation improved nutrition attitudes by 50 percent, and 21 percent improved food selection as a result. Nutrition education enabled Arizona to decrease plate waste by as much as 45 percent in some schools by increasing the willingness of students to try new foods (McGinnis, 1983).

Nutrition education is especially important for older individuals, since a number of issues may affect their food consumption and consequently, their health:

- Changing nutrient requirements due to disease and/or the aging process; for example, a sodium-restricted diet to control hypertension.
- Factors influencing desire to eat, such as loneliness, or the death of a spouse or close friend.
- Factors influencing ability to obtain or prepare meals; e.g., financial constraints, decline in physical or mental status, frequency of access to food shopping.
- Degree of belief in nutrition misinformation. Many older individuals spend money unnecessarily on vitamin and mineral supplements, which could be toxic at high levels or cause adverse effects in combination with certain drugs.

A dietitian who has worked with local programs says, "I think that very often, our participants come in, eat one good meal, then go home and snack or perhaps not eat another meal. Or they skip breakfast because they got up late, come in to a congregate site and have a meal, then just have a snack of cereal, soup, toast, or other easy-to-prepare foods" (Diggins, 1984). These individuals need to learn ways to get the nutrients they need by eating foods they like that are easy to prepare and fit into their budgets. New approaches by dietitians include the Liberalized Geriatric Diet, which encourages calorie consumption while discouraging most diet restrictions, except when significant therapeutic benefits will follow (Luros, 1983).

Because nutrition education is not mandated in the Act, few state and area agencies spend nonfederal money on nutrition education. A 1980 N4A survey revealed that 90 percent of nutrition projects spent no state dollars on nutrition education, and that 79 percent spent no local funds. Forty percent spent no federal money on nutrition education, and more than half did not require nutrition education at all. Given shrinking resources, further erosion in this area is anticipated.

2. Fund nutrition education as a separate line item under Part B, Supportive Services and integrate nutrition education with health promotion. The importance of health promotion, including nutrition education, for older individuals has been recognized by Congress, where Rep. Ike Andrews (D-NC) has introduced H.R. 4472. The bill would amend the Older Americans Act to add a new Title VII for the purpose of designing and implementing a uniform, standardized program of health education and training for older Americans.

A 1983 pilot program in Ohio called SHEPP (Senior Health Education Promotion Program) trained students in nursing, nutrition, sociology, and health education to discuss topics of interest with older individuals during lunch. A survey of congregate participants at three sites indicated that more than 70 percent wanted to know more about their health. Health topics of most interest to participants were stress management/relaxation, arthritis, nutrition, hypertension, and fitness. The survey revealed that 58 percent did not know basic nutrition.

If the pilot is well received, SHEPP will be expended to other sites. While results are not in yet, the program is notable because it networks efforts of several public and private health agencies and universities, and because it cost very little to plan (Horvath, 1983).

This inexpensive approach to nutrition education should be encouraged, since nutrition project staff worry about stretching their limited resources just to meet the basic human need for food. "The major problem noted, at all staff levels, is funding. Staff members are greatly concerned over the need to increase the availability of meals to unserved elderly, to increase the schedule of meal service, and to expand the number and coverage of support services available to participants" (Kirschner/ORC, 1983). Although nutrition education is a supportive service, it is erroneously placed in the Act under Part C, Nutrition Service. No wonder no funds are allocated for nutrition education--it would be like taking food out of someone's mouth!

3. Require qualified dietitian-nutritionists to plan, develop, and evaluate participative nutrition education experiences; to train others to conduct nutrition education activities; and to provide individualized nutrition counseling for participants on therapeutic diets. Nearly all the nutrition project managers surveyed by N4A said that nutrition education is essential, and that they needed training on ways to improve nutrition education activities. Several training manuals have been developed at the federal level to meet this need, but there is no money to print or disseminate them.

A more cost-effective approach is training by a qualified dietitian-nutritionist. Given adequate funding and technical assistance from a dietitian, nutrition education experiences can be designed to involve participants, increase their nutrition knowledge, and improve participants' food selection, which will result in positive health outcomes. Nutrition education can be tailored to meet the needs of minority participants and those from different ethnic groups, so the foods discussed can match the foods they eat.

A disturbing finding from the Kirschner/ORC report was former participants' reasons for dropping out: their health problems conflicted with attendance, the food was not to their liking or they needed a special diet, or they now cook for themselves. While the last reason should be applauded, the other two indicate a need for home-delivered meals and for the services of the dietitian to improve meal acceptability and provide nutrition counseling for participants on therapeutic diets.

Eighty-six percent of older individuals suffer from at least one chronic disease, and at least one-third of older individuals require physician-prescribed therapeutic diets (Catakis, 1981; ADA, 1975). This means that more than half a million regular participants may not be receiving the special meals and/or nutrition counseling that they need, since neither are required in the Act. The Kirschner/ORC report states that more than half of all sites do not provide special meals based on health needs or ethnic preferences. Personal nutrition counseling was reported to be available at 61 percent of the sites studied; but its usefulness is severely limited if it can be offered only once a month or less. The N4A survey found only 47 percent of sites providing this service. Personal counseling is virtually unavailable to home-delivered meals participants; these older, sicker participants are precisely the population that nutrition counseling could help the most. Since they are more isolated, the social contact would be a side benefit of great value.

4. Participants must be involved in planning nutrition education activities. While 66 percent of the projects in the N4A survey indicated that they did so, that still leaves one-third of sites where there is room for improvement. As Kohrs (1979) states:

"Nutrition education for older persons can provide knowledge for selecting, storing, and preparing the foods that will give healthful, balanced diets. One pilot nutrition education project showed that nutrition classes can be successful in gaining participation from older people and also in bringing about improvement in their nutritional knowledge. However, nutrition education programs for older adults need to be carefully planned and conducted to achieve desired objectives. It seems essential that senior citizens be involved in their planning and executing and that competent personnel with adequate technical training provide responsible leadership."

OLDER AMERICANS ACT REAUTHORIZATION

ADA POSITION STATEMENT

Issue: Food Safety and Sanitation

A. **ADA Position:**

Specify minimum standards for food temperatures and holding times, and compliance with federal, state, and local health and safety laws and regulations, in the Act. This is essential to prevent foodborne illness, which could seriously threaten the lives of participants.

B. **Proposed Modifications to the Act:** (in chronological order)

- Section 337, "Criteria"

  Proposed wording: "The Commissioner, in consultation with organizations of and for the aged, blind, and disabled, and with representatives from the American Dietetic Association, the Association of Area Agencies on Aging, the National Association of Nutrition and Aging Services Programs, the National Association of Meal Programs, Incorporated, and any other appropriate group, shall develop minimum criteria of efficiency and quality for the furnishing of meal services for projects described in section 331, paragraphs (1) and (2). Project sites shall comply with federal, state and local health and safety laws and regulations. Such standards shall include, at minimum, the requirement that hot foods shall be not less than

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140 degrees Fahrenheit, cold foods shall be not more than 45 degrees Fahrenheit, and holding times for ready-to-serve foods shall be not more than 2 hours, including preparation, loading, and all stages of meal transport. Other criteria required by this section shall take into account the ability of established home delivered meals programs to continue such services without major alteration in the furnishing of such services."

C. Position Rationale

"Preventing foodborne illnesses should be a major concern for all personnel affiliated with the nutrition services for older Americans. The participants in these programs are among those most susceptible to severe illness and even death when foodborne illnesses occur" (McCool and Posner, 1982).

Several findings in the Kirschner/ORC report (1983) point to the need for minimum standards and increased training in this area:

- Shift in meal preparation arrangements from outside contractors (69 percent of sample in 1976) to providers (56 percent of sample in 1982). Providers prepare meals on site (26 percent) or at central kitchens (30 percent), delivering food in bulk at serving temperature to sites. When providers prepare meals at central kitchens and deliver them to sites, they have the control to monitor the process closely, but need to know what to watch for. When providers go out to bid with an outside caterer, control can be lost unless certain specifications are written into the contract.

- During the same period (1976-1982), the proportion of meals that are home delivered has nearly tripled.
- Although food service and sanitation practices were cited as the most frequent training area for staff, nutrition service directors said that additional training was needed in this area.
- Nutritionists/dietitians surveyed noted long delivery routes and consequent temperature problems, inappropriate menus, and difficulties locating and keeping qualified meal preparation staff as common problems in the system.
- For home-delivered meals, nutrition service directors noted needs for thermal containers and strategically-designed, short delivery routes. Training of drivers and periodic monitoring of food temperatures and food handling were also cited as important for maintaining safe and sanitary service.

The 1981 evaluation of food service delivery systems, also performed by Kirschner Associates, concluded that "sanitation and food temperature control standards were not being met consistently, that certain project sites were serving food which could be considered potentially unsafe to eat, and that a large number could and should improve their basic sanitation practices." About half the sites sampled had sanitation survey scores that indicated increased chances for significant problems (Kirschner, 1981).

Obviously, these are not isolated incidents, and problems happen at even the best-run sites, as noted in the 1981 evaluation and since then by dietitians working in the program. In another AoA-funded study, McCool and Posner (1982) found that a majority of projects experience a 4-hour time lapse between initial preparation and service. A project dietitian has observed "food delivered without adequate covering and packaging, dishes that have not been properly sanitized, key equipment such as stoves and dishwashers that did not work, and sites and home-delivered meal routes with no temperature maintenance equipment between preparation and service" (Prophet, 1983).

Because most nutrition projects utilize a cook/serve or cook/satellite food service system, there are more potential stages at which bacteria can contaminate food then in other types of food service systems (i.e., cook/chill, cook/freeze, or assemble/serve). The highest-risk points in cook/serve and cook/satellite systems are: receiving and inspection, thawing, preparation/initial cooking, hot holding, portioning, assembly/packaging (in a cook/satellite system), transportation, food holding and service. Exposure to temperatures between 45°F and 140°F must be minimized to prevent growth of dangerous bacteria such as *salmonella*, *staphylococcus*, or *C. perfringens*. Foods that support rapid growth of these bacteria include milk, eggs, meat, poultry, fish, and shellfish.

A major cause of nutrition services' food safety problems appears to be overlong food holding due to inadequate planning, packaging, and transportation constraints. The risk of foods reaching the temperature danger zone rises after holding two hours, and there is considerable loss of water-soluble vitamins (e.g., B-vitamins and vitamin C) after hot holding only one hour. High-temperature holding has additional drawbacks: nutrient losses are most severe when food is held hot, and dried-out food resulting from long periods of hot holding is unappetizing.

What can be done? Certainly, there is a variety of instructional material available—but you cannot throw a handbook to dedicated, hard-working volunteers with no food service management background and expect them to absorb it. Nor can there be complete reliance on state and local codes, which often take their cues from federal policy and which are sometimes haphazardly enforced. A mandate in federal statute to comply with minimum food safety standards is needed. Complete and continuous training for project staff and volunteers is the implementation strategy that will effect rapid improvements in problem areas and prevent outbreaks of foodborne illness.

A dietitian-nutritionist can work with the nutrition project manager and/or food service manager to train project staff in procedures to ensure that participants are protected from foodborne illness. These procedures include: proper cooling practices, proper hot-holding practices, adequate reheating, adequate cooking of potentially hazardous foods, procurement of foods from safe sources, prevention of cross-contamination (e.g., blood from refrigerated raw beef leaking into cooked food on shelf below), and prevention of contamination by workers and from other sources (e.g., storing high-acid foods in zinc containers). Sanitation procedures that can be taught include: personal hygiene, protection of food, cleanliness of tableware/kitchenware/equipment, checking for proper construction and repair of facilities, access to adequate equipment, checking for proper construction and repair of equipment, and general sanitation and cleanliness of facilities.

We urge you to consider carefully this widespread, serious and potentially life-threatening problem, and to include strong legislative language in the Act to require that this situation be corrected.

OLDER AMERICANS ACT REAUTHORIZATION

ADA POSITION STATEMENT

Issue: Nutrient Standards

A. ADA Position:

1. Continue the present nutrient standard of one-third RDA as the minimum per-meal requirement. Use the highest calorie standard recommended (e.g., in the 1980 RDAs, the highest calorie standard is for men 51-75 years). Do not reduce requirements for any of the macro- or micronutrients.
2. Reinstate the requirement that project sites serve meals at least five days per week. Require that one project site per area provide for home-delivered meals seven days per week.
3. Require menu planning and meal supervision by a qualified dietitian-nutritionist. This individual keeps abreast of the research literature on nutrition and aging, and is trained to find ways—within budgetary constraints—to increase nutrients in which segments (or all) of the older population are deficient.

B. Proposed Modifications to the Act: (in chronological order)

- Section 307(a)(13)(G), "State Plans"

  Proposed wording: "each project shall utilize the services of a qualified dietitian-nutritionist to plan menus for medically prescribed special diets, supervise the preparation and serving of meals to ensure participant acceptance, and meet

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approved by BOD

health requirements, religious requirements, and ethnic requirements of eligible individuals;"

- Combine Subpart 1 and Subpart 2 under Part C to read as follows:

"Part C-Congregate and Home Delivered

Nutrition Services

Program Authorized

Section 331. "The Commissioner shall carry out a program for making grants to States under State plans approved under section 307 for the establishment and operation of nutrition projects for older individuals--

(1) which provide, at least 5 days per week at each congregate site, one hot or other appropriate meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council;

(2) which provide for 7 days per week, at least one home delivered hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life) meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide, each of which assures a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council."

C. **Position Rationale**

Only recently has attention been paid to the subject of nutrition for older individuals, and much remains to be learned. Dr. Hamish Munro (1981) divides the relationship of nutrition to aging into three issues:

. We do not know how much nutrition influences the course and severity of the progressive changes in bodily functions that occur as the adult grows older;

. Nutrition is one of the prime candidates among factors causing age-related degenerative diseases such as atherosclerosis and cancer;

. We have inadequate knowledge concerning the nutrient needs of people once they have attained old age and generally consume much less food than they did as young adults.

A recent article (Bowman and Rosenberg, 1982) proposes three questions that must be asked when discussing studies that attempt to measure nutritional status in older people:

"1) When nutritional deficits are observed in elderly persons, do they represent dietary lack or dysfunction of digestion, absorption, or utilization?

2) Are functional changes that are observed in an older person biological or pathological, i.e., are they related to the physiology of aging or do they reflect the impairment of degenerative disease?

3) Are separate standards needed for evaluating the nutritional and health status of the elderly?"

These authors also note that "many of the symptoms of subclinical nutrient deficiency--including fatigue, irritability, decreased appetite, anxiety, loss of recent memory, insomnia, distractibility, and mild delusional states--are often considered 'normal' concomitants of aging."

Another researcher (Love, 1982) notes that:

"Research in the field of geriatric nutrition is made difficult by poor subject cooperation and high incidence of chronic physical and psychologic illness. Assessment of nutritional status of the aged is difficult, since there is no precise information on the minimum requirements of many nutrients and of various biochemical indices. The recommended dietary intakes are defined to meet the needs of practically all 'healthy' persons, and do not include the increased requirements for nutrients that may be present in chronic disease, metabolic derangements, or the aging process."

Munro (1981) distinguishes the causes of malnutrition in older individuals as either primary or secondary. Primary causes are: 1) Ignorance of the need for a balanced diet, especially among widowed old men; 2) Poverty, which influences the range of foods available; 3) Social isolation resulting in loss of interest in food; 4) Physical disability, which restricts capacity to purchase varied foods; 5) Mental disorders, confusion, and depression, which are more common in elder people, and are incompatible with normal nutrition. Secondary causes include: 1) Malabsorption due to a variety of intestinal conditions; 2) Alcoholism, which can cause malnutrition and affect nutrient absorption; 3) Therapeutic drugs, commonly taken by older people, which can interfere with nutrient utilization.

Current research literature indicates that the following nutrients should receive special attention in meals for older individuals (Kohrs, 1983; 1982; 1981):

- Calories. The assumption that older individuals have a reduced need for energy due to a slower metabolism and less activity must be viewed in light of consistent findings of low-calorie intake among nutrition service participants. The Kirschner/ORC report confirms this finding, with 32 percent of study participants consuming less than 1200 kcal per day. Eating less than 1200 kcal a day makes it almost impossible to meet RDAs for macro- and micronutrients.
- Protein. Recent studies suggest that older individuals should consume daily between 0.8 gm to 1 gm [illegible] protein per kilogram of body weight. Use of medications, recent surgery, and chronic illness appear to increase the need for protein. In addition, lower socioeconomic groups consume less than the RDA for protein. Since these groups are a priority target for nutrition services, the 3 oz meat (also a good source of iron) requirement is especially important to the well-being of older individuals.
- Calcium. A deficit in calcium, one of the nutrients most frequently lacking in the diets of older women, is associated with osteoporosis, although the pathogenesis of bone deteriora-

tion is unclear. The Kirschner/ORC report also documents this deficiency, with only 64 percent of congregate participants and 58 percent of home-delivered meal recipients meeting 2/3 of the RDA for calcium. Some researchers suggest that after menopause, women should consume up to 1500 mg per day. The current RDA is 800 mg, but most American women over 45 consume only 450 mg per day (Brody, 1984). Of the $1 billion spent every year to heal hip fractures, 90 percent happen to women over 60 (Suplee, 1983).

- Vitamin A. Absorption of Vitamin A and other fat-soluble vitamins can be reduced by laxatives and antibiotics. This problem is exacerbated by inadequate intake, which was reported for 30 percent of congregate participants and 36 percent of home-delivered meals recipients studied by Kirschner/ORC.
- Iron. Very little is known about the bioavailability of dietary iron in the diets of older individuals. What is known is that anemia is a major nutritionally-related problem among older people, and dietary iron deficiency may play a part.
- Vitamin C. Vitamin C is important to iron absorption. Improved intake of vitamins A and C has been associated with program participation in previous evaluations of Older Americans Act nutrition services, although the relationship between participation and increased vitamin C intake is not significant in the Kirschner/ORC study.

- B vitamins: thiamin, riboflavin, niacin, folacin, B_6, B_{12}. B vitamins are important for neurological functions, and deficiencies in certain B vitamins (folacin, B_{12}) may contribute to a type of anemia in older individuals, especially blacks. While the Kirschner/ORC report would indicate that increased enrichment by the food industry has largely alleviated B-vitamin deficiencies for participants, a recent study (LeClerc and Thornbury, 1983) revealed low thiamin intakes in a nutrition services participant group.
- Zinc. Important in healing wounds, taste acuity, and immune function, zinc is consumed by older individuals at a rate of 8-9 mg per day. This is only 60 percent of the RDA of 15 mg, and may indicate a borderline deficiency.

While more research is needed on RDAs for older individuals, especially those over 85, the current RDAs represent the best available guidelines. Other guides can be found in various federal publications that discuss the relationship of diet to disease and recommend limiting consumption of sodium, fat, cholesterol, sugar, and alcohol. The one-third RDA requirement for meals can be applied with confidence, since the research to date would appear to indicate that, if anything, certain RDA values are low and consumption of food sources of certain nutrients needs to increase.

Nutrition services provided under the Older Americans Act have greatly improved nutrient intake of participants. The Kirschner/ORC report confirms the program's contribution, noting dramatic increases in daily intake of those who consume a meal. The researchers suggest that this may be the only nutritious meal that participants consume that day, and some participants have confirmed that the program meal is used as half--not one-third--of their daily intake.

Right now, projects are serving only five meals out of a possible 21--and some sites are serving less. Having firsthand experience with nutrition projects, we know and can appreciate the realistic constraints placed upon nutrition services by limited funding and heavy reliance on volunteer labor.

In a country where 13 million older individuals have inadequate diets and malnutrition cuts across all socioeconomic strata, it is high time that we concentrate our efforts on alleviating this problem and preventing its expensive results (Posner, 1979). Home delivered meals participants are at high risk of institutionalization--yet they cannot obtain a single meal on weekends unless state or local agencies, relatives, or friends suddenly materialize those two days a week and fill the gap. It is essential for at least one site in each area to assure that meals are available 7 days a week so those people who can't heat, refrigerate, or otherwise prepare their own meals can eat on the weekends. We're not suggesting that cost efficiencies, such as delivering two frozen meals with a hot one, be discontinued--only that they be augmented by weekend service for those people who really have no option but to go without eating. We suggest that resources such as Meals-on-Wheels programs, home health care agencies, and other options available in the community be utilized first, whenever possible, to ensure weekend home-delivered meals. However, the nutrition project should retain ultimate responsibility. This will take additional funds, and we urge a swift assessment of this unmet need so additional appropriations can be granted as soon as possible.

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Senator **Grassley**. Yes. I will wait until we are done with all the panel before we proceed to questions. Ms. Sheeler.

Ms. **Sheeler**. My name is Peggy Sheeler. I am past president of the National Association of Meal Programs and their legislative committee chairman. Mr. Chairman, at this point I do feel that I am a poor second to Mamie Lee, the president who died 2 weeks ago.

As many of you know, the National Association of Meal Programs is an association of community meal programs, both congregate and home-delivered Meals on Wheels. The programs have their foundation and structure in their communities. Their boards consist of people living in the community.

They receive contributions and donations from individuals and other groups in their community. They depend heavily on volunteers to operate the programs and deliver services, both the meals and the emergency and supportive services which are so much a part of both the group and the Meals on Wheels Programs.

The National Association on Meal Programs is grateful to you for giving us the opportunity to present to you our concerns and our suggestions relating to the reauthorization of the Older Americans Act. We have already submitted proposed language changes to the committee staff in extended written testimony. So today I would only like to highlight some of these areas.

We are concerned about community and voluntary groups being included in what is called the aging network. The sense of the Older Americans Act lies in the pooling of public and private resources to meet the needs of older people who can with support live in their own community. Congress showed real wisdom in our view in trying to create a structure and a planning and service support network which maximizes the ability and the desire of individual families and communities to care for their own and yet have available those public resources needed to fill the gaps.

We are finding in our communities that some area agencies are more comfortable with the traditional role of giving the funds for the delivery of specific units of measurable services to specific people. This type of funding and accountability makes it easier to state what Federal dollars have bought what service. We understand that.

All of us know that we have to maximize those Federal funds by use of community resources, which make it possible to increase the number of people that we are actually able to assist. In many instances this means further utilization of community involvement, private contributions, and volunteers.

I would suggest to you that the model structure for this joint effort of pooling resources lies in community meal programs.

You have some knowledge of such programs in your own community and you know how many people are often involved and the importance of what they offer. These programs receive anywhere from zero to 40 to 50 percent of their cash budget through the Older Americans Act structure. Added to this are the hundreds of thousands of hours of volunteers, donated space, donated food, donated emergency care, and other supportive services.

While in some areas the community meal program is considered part of the aging network and is involved in assessing needs, planning and delivering of these services, we find in some areas that the community meals program is being undermined by the use of Older Americans Act funds to pay another provider to serve meals in the same geographical area, sometimes without charge, sometimes with payment to volunteers as well.

In a few communities the community meal program went out of existence when the area agency started preparing the meals. In some instances the area agency is putting preparation of meals out for bid, separated from the supportive services and the delivery to the home.

In one instance a for-profit provider underbid a community nonprofit program, and then the area agency had to contract for the supportive services, with the bottom line that the cost increased and fewer meals were served.

We are watching a situation at this point in time where a voluntary, nonprofit Meals on Wheels that has been operating since 1971, had the assessment and reassessment taken over by the area agency and in this same instance based on the information that they received they were not able to adequately serve the individuals and they had to go out and assess again.

They contacted me just last week and told me now they are going to be faced with a bid process under which the meal preparation and the supportive services and delivery are going to be separated, and so they are not going to be able to continue.

Another instance that I can cite is one where the bid process under the local governmental structure, which normally has to do with bricks and mortar and building bridges is being applied to

Meals on Wheels. It does not address human needs. And in this instance, this nonprofit organization had to put up $9,000 to engage in the bid process and had to put up $150,000 as a performance bond when there was no competitor and they had been providing the service for 23 years.

The community meal program is not taken seriously as a provider of services; sometimes it is because the deliverers of the services are not paid and they are not considered professional when they are not receiving a salary.

The community meal program is sometimes not considered a part of the aging network, and some of the programs do not receive any funds at all from the Older Americans Act, but need to be considered when the planning is being done for the aged in their communities so that they are able to contribute even if they are not receiving any of the Federal funding.

We believe that the emphasis for the AAA's should be in the area of planning and coordination and on broadening the concept of the aging network rather than moving into the area of case management and assessment.

We need to work to preserve the community involvement and the supportive community organization and the incentives for the community to work to establish the networks and structures that help the more frail older people to maximize all of the resources that we have in this time when we are having diminishing resources to meet the needs of an ever increasing number of people who need assistance.

We emphasize the need for the most cost effective service delivery system and we want to be sure that those services provided by families and community networks in concert with the professional staff of agencies that are contracted and paid provide the maximum number of units of services that we can possibly provide in a joint, concerted, coordinated effort.

The National Association of Meal Programs and its members want the aging network to work to be successful, even more successful. What I have raised with you are problems and concerns which have emerged in several communities. We believe that we need to continue to work together to understand the unique problems of organizations such as nonprofit community meal programs that maximize the use of volunteers in order to have an effective delivery service.

And we appreciate the opportunity to express our concerns and our views to you today.

[The prepared statement of Ms. Sheeler follows:]

National Association of Meal Programs

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Subcommittee on Aging, Committee on Labor & Human Resources
Hearings on Reauthorization of the Older Americans Act
February 24, 1984
submitted by the National Association of Meal Programs

I am Peg Sheeler, Past President of the National Association of Meal Programs, and Legislative Committee chair. As many of you know, the National Association of Meal Programs is an association of community meal programs, both congregate and home-delivered/Meals on Wheels. The programs have their foundation and structure in their communities; their boards consist of people living in their communities; they receive contributions and donations from individuals and other groups in their communities; they depend heavily on volunteers to operate the programs and deliver services-both the meals and the emergency and supportive services which are so much a part of both the group and the Meals on Wheels meals programs.

The National Association of Meal Programs is grateful to you for giving us this opportunity to present to you our concerns and our suggestions relating to the reauthorization of the Older Americans Act. We have already submitted proposed language changes to the Committee staff, and extended written testimony. Today I want to discuss with you the importance of participation by community groups, voluntary groups, in the so-called "aging network."

To us the strength of the Older Americans Act lies in the pooling of private and public resources to meet the needs of older people who can, with supports, live in their own homes and communities.

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where eating means caring and sharing

Congress showed real wisdom in trying to create a structure and a planning and service/support network which would maximize the ability and desire of individuals, families, communities to care for their own, yet have available those public resources needed to fill the gaps.

The Congress was creative. We are finding in our communities that some Area Agencies on Aging are more comfortable with the traditional role of doling out funds for delivery of specific units of a measurable service to specific people. This type of funding and accountability makes it easier to state that federal dollars have bought what service. But I think all of us here are more interested in what can be done through use of federal funds to strengthen community resources, to *multiply* the units of service, to *geometrically* increase the number of people served because that extra funding has meant more volunteers, more community involvement, more private contributions.

I would suggest to you that the model structures for this joint effort and pooling of resources lie in our community meal programs. Each of you, I am sure, has some knowledge of such a program in your community. You know how much people are involved, and how important giving and serving is to them. These programs now receive anywhere from 0 to 40 or 50 percent of their cash budget through the Older Americans Act structure. Added to this are the hundreds of thousands of hours of the volunteers, the donated space, the donated food, the donated emergency care and other supportive services.

While in some areas the community meal program is considered part of the "aging network" and is involved in assessing needs, planning, delivering service, we find in other areas

*the community meal program is being undermined by the use of Older Americans Act funds to pay another provider to serve meals in the same geographical area, without charge, and sometimes with payment to volunteers as well

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*the community meal program goes out of existence when the Area Agency decided to provide the meals directly

*the Area Agency put preparation of meals out for bid, separated from the supportive services and the delivery to the individual home, a for-profit provider is able to underbid the community program, and then the Area Agency has to contract for the support services, with the bottom line in costs being twice what it had been with the community meal program

*the community meal program is not taken seriously as a provider of services, partly because the deliverers of the service are not paid staff, are not "professionals"

*the community meal program is ignored by the Area Agency on Aging, and the "aging network" if they do not receive Older Americans Act funds.

On the whole little community planning or organizing takes place with or by the State Units and the Area Agencies on Aging. Rather what is emerging is the National Association of Area Agencies on Aging suggesting that the name of Title III be changed to "Grants for Community Based Long Term Care Services" and that the functions of the AAA be more and more directed to providing assessment and case management for referrals to agencies for provision of service. This emphasis, and N4A is serious about it, should tell us where the Area Agencies are headed. The community involvement, the support for community organizations and the incentives for communities working to establish networks and structures that help their more frail older residents, are not part of this Area Agency plan.

Although we understand that the Congress does not intend to make such a change in the Older Americans Act, we suggest that the Congress does need to recognize that this is how some Area Agencies are behaving, how they are relating to community groups, and how they perceive their role and responsibility. These Area Agencies do not see themselves as being responsible to communities; they do not understand community organizing; they do not understand resource development within communities; they do not recognize community organizations or their ability to meet the needs of the frail elderly, thus allowing these persons to remain in their own homes and communities.

We here know that the most cost effective service delivery system is that provided by family and community support networks, not by "professional" staff of agencies contracted and paid to provide units of service. Sometimes professionals are needed; we simply want to ensure that the much larger service network, that of the voluntary organizations and groups and families and neighbors, is facilitated, is supported, is recognized, is encouraged. This is the only way we shall be able to provide for the increasing number of frail elderly. The amount of money which would be needed to replace community meal programs, and to provide the expanded services which we see these programs moving toward, is not available. And, we might ask, why should it be, if we can find the resources in ourselves and our communities?

Community meal programs are there to meet a need. If they are not needed-if government through the Older Americans Act and the Area Agencies on Aging wants to purchase these services or provide them directly-then government will have to plan on coming up with many times the amount of money now appropriated. If this is not the intent of the Congress, and of the Older Americans Act, and we believe it is not, then it is essential that the State Units on Aging and the Area Agencies on Aging be so informed, and be directed to carry out the responsibilities so clearly outlined in the Older Americans Act. In the reauthorization we have proposed some language changes which we hope will strengthen this directive from the Congress. We ask your support and action.

The National Association of Meal Programs and its members want the "aging network" to work, to be successful. What I have raised with you are problems and concerns which have emerged in several communities as the Area Agencies have evolved. We believe they can evolve further into effective community planning, coordination, organizing agencies, thereby ensuring that older people themselves, that community meal programs and other community service organizations, are strengthened and helped through the most cost effective, humane, and caring structures to provide the services and supports that make it possible for frail older people to live independently and in their own homes and communities.

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Senator **Grassley**. Thank you very much. Mr. Moyer.

Mr. **Moyer**. Mr. Chairman, I am William Moyer, president of the National Association of Nutrition and Aging Services Programs [NANASP]. Thank you for the opportunity to testify on behalf of NANASP.

The nutrition program for the elderly represents a major service of title III of the Older Americans Act. The program serves over 200 million congregate and home delivered meals each year and represents over 50 percent of the funding commitment in the act.

Yet hunger among the elderly, as reflected in the recent Kennedy hunger hearings, remains a national problem, and I urge this subcommittee to renew its commitment to prioritize the alleviation of hunger and to increase funding for this purpose.

At this hearing I have been asked to provide testimony on the method of meal preparation, ethnic diets, nutrition education and standards.

Since I have submitted written testimony to the subcommittee and since Kirschner Associates in their nationwide study, comprising three volumes, did an excellent job assessing similar areas, I will only highlight here.

Concerning methods of meal preparation, two major methods exist, on site and catered, comprising approximately one-fourth and three-fourths, respectively. Either method would be the method of choice when such factors as volume, site location, community resources, and of course costs are considered.

There also exist combination methods such as precooked, refrigerated, transported to the sites, and finished off at the sites, or the example of frozen bulk foods that are prepared at the sites.

Regarding home delivered meals, most are identical to the congregate meal, delivered temperature ready to the home. However, a significant number of programs offer separate meals that may be frozen, freeze dried, or retort pouch meals, and these methods deserve further study, since they offer exciting and cost effective alternatives to homebound clients.

Ethnic meals are served in numerous areas throughout the country and have been since 1973. These meals, while generally more expensive than regular meals due to special foods and lower volumes, are effective in attracting ethnic participants.

However, Kirschner Associates found that the three most important variables in attracting ethnic participants were minority staff, affirmative action hiring policies, and other special assistance, such as clothing or wheel chairs, available at the sites to participants.

From this finding, "faces" rather than "food" may be more important in attracting ethnic participants and would point to the need to strengthen and reemphasize affirmative action hiring practices in the reauthorization of the act.

Nutrition education exists at most sites throughout the country and generally consists of either basic facts about food and nutrition or nutritional practices such as food purchasing or meal preparation. The value of nutrition education in teaching such things as assuming the cooking role once performed by a spouse, dealing with chewing or digestive problems, or creating simply a new excitement about the importance of nutrition to health is considerable. Its importance is recognized by we who are in daily contact with the elderly participants, and its emphasis should be strengthened in the act.

Maintaining high quality services has long been a priority of congregate and home delivered nutrition staff. Congress, too, recognized this priority early be requiring base level training for nutrition project directors when the program first began. However, such training has not been required or even available to many of us for the past 8 years.

States vary considerably in providing policies and guidelines, let alone training, and Federal regulatory guidance is all but nonexistent beyond the fact that the meals should meet one-third RDA. In response to this concern for quality nutrition services, the National Association of Nutrition and Aging Services Programs recently developed and adopted program standards for both congregate and home-delivered nutrition programs.

These standards were developed with input from throughout the aging network and, in our opinion, are the best available standards for nutrition program operations. NANASP urges this subcommittee to include these standards by reference in the reauthorization of the act.

Though testimony was only requested in the areas cited above, it is critical to indicate to this subcommittee that while important, these areas are not the only areas of concern to us. A major concern relates to the recent administration budget request and its recommendations regarding reauthorization of the Older Americans Act.

As you know, the administration has proposed, among other things, a consolidation of title III programs into a single grant. If agreed to by Congress, this would, in effect, eliminate the Federal mandate for congregate and home-delivered nutrition programs for the elderly.

Instead of the separate categorical funding for these nutrition programs, States could choose to spend the money for any aging service program authorized under the act. In addition, the administration has proposed to transfer the USDA cash/commodity program from the Department of Agriculture to the Department of Health and Human Services and include this amount into the "aging block grant" to the States.

This would end reimbursing nutrition projects for meals served. Rather, it would be given to the States on a formula basis, be subject to administrative costs by State and area agencies on aging, and as a consequence, it would result in a dramatic loss of funding for nutrition programs for the elderly.

It is also important to point out to this subcommittee that block granting the Older Americans Act will do little to increase local flexibility. The Older Americans Act is unique in that it requires local planning and decisionmaking already through the mandated aging network of State units and area agencies on aging.

I strongly urge the Congress to reject any attempts to block grant the Older Americans Act and to continue the USDA cash/commodity program as is with funds distributed to the field based on the number of meals served and that these funds be used only to provide additional meals.

Finally, I would like to request that this subcommittee advocate for increased appropriations for all services provided through the Older Americans Act. It appears to me that there is something very wrong with our priorities when we would rather spend our limited national resources on thermonuclear weapons that, with God's help, we will never use rather than on meals and other vital services that, with your help, we will use.

Thank you.

[The prepared statement of Mr. Moyer follows:]

TESTIMONY

FOR A HEARING ON TITLE III

OF THE OLDER AMERICANS ACT

SUBCOMMITTEE ON AGING

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

FEBRUARY 24, 1984

STATEMENT BY WILLIAM R. MOYER, PRESIDENT
NATIONAL ASSOCIATION OF NUTRITION
AND AGING SERVICES PROGRAMS

1601 SECOND AVENUE, SUITE 800
SEATTLE, WASHINGTON 98101

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Mr. Chairman and Members of the Subcommittee on Aging:

I am William R. Moyer, a Nutrition Project Director from Seattle, Washington and President of the National Association of Nutrition and Aging Services Programs (NANASP). I thank you for the opportunity to testify on behalf of the National Association of Nutrition and Aging Services Programs at this hearing on Title III of the Older Americans Act.

As the Subcommittee is aware, Title III of the Older Americans Act provides funding for a National Nutrition Program for the elderly. This program operates through over 13,000 Nutrition Sites throughout the Country and serves in excess of 200 million congregate and home-delivered meals per year to the Nation's elderly. In terms of the Older Americans Act, this represents a major committment. Indeed, over fifty percent of the total funds provided in the Act are for the provision of meals, nutrition education and outreach. Despite this committment, hunger among the elderly remains a National problem vis-a-vis "Going Hungry in America" - A Report by Senator Edward M. Kennedy to the Committee on Labor and Human Resources, United States Senate,(1) and I urge this Subcommittee to renew its committment to prioritize the alleviation of hunger and to increase funding for this purpose. At a previous hearing before this Subcommittee, I had an opportunity to testify on behalf of NANASP on the subject of Targeting Resources To Insure That Services Provided Under The Act Reached Those Elderly In Greatest Ecnonomic and Social Need. At that hearing, now a matter of Public Record, I Shared With The Subcommittee Demographic Data About "Who" Was Being Served By Congregate and Home-Delivered Nutrition Programs Funded Through The Older Americans Act.

At This Hearing, I Have Been Requested To Provide Testimony On "What"

Nutrition Programs are doing with specific emphasis on method of meal preparation, Ethnic Diets, Nutrition Education and Standards Involving Nutrition Programs.

The two major methods of meal preparation at Congregate Nutrition Sites are "On-Site", when the meals are prepared at the same location where the meals are served, and "Catered" where the meals are prepared at another location and brought to the meal site for serving. Nationwide, approximately one fourth (1/4) of the meals are prepared "On-Site" and three fourths (3/4) are "Catered" either through an independent Contractor or a central kitchen prepared by Nutrition Program Staff.(2) Each method has its advantages and either would be the method of choice after reviewing such factors as volume, site location, quality considerations, community or project resources, and of course, costs. There also exists a number of combination methods such as pre-cooked meals that are then refrigerated and transported to the sites with final cooking occurring at the sites (where the vegetables are also prepared) and the example of frozen bulk food that is in turn cooked and served at the sites.

Regarding home-delivered meals, the majority (75% to 80%) are identical to the meal served in the Congregate program and the meals are generally delivered to the home "temperature-ready". However, in a significant number of areas other separate meals are delivered to the homebound and may be frozen, freeze-dried, shelf stable retort pouch meals or others and it is this area that deserves further study by this Subcommittee as well as those of us in the field. It is likely in this area that new technologies will emerge or already exist that hold considerable promise for the future.

ETHNIC MEALS, ANOTHER AREA WHERE TESTIMONY WAS REQUESTED, HAVE BEEN SERVED IN MANY AREAS OF THE COUNTRY, UNDER OLDER AMERICANS ACT AUSPICES, SINCE THE NUTRITION PROGRAM FOR THE ELDERLY WAS ESTABLISHED IN 1973. THE NUMBER OF SUCH SITES SERVING ETHNIC MEALS, HOWEVER, AS WELL AS THE PERCENTAGE OF ETHNIC MEALS TO THE TOTAL IS NOT COLLECTED AND NOT KNOWN TO MY KNOWLEDGE. SUCH PROGRAMS, NATURALLY, EXIST IN THOSE AREAS WHERE A SUFFICIENT NUMBER OF IDENTIFIABLE ETHNIC POPULATIONS RESIDE.

IN THE SEATTLE/KING COUNTY AREA, FOR EXAMPLE, THERE ARE EIGHT ETHNIC SITES, ALL OF WHICH SERVE ETHNIC MEALS. THESE SITES PRIMARILY SERVE FIRST GENERATION IMMIGRANTS,MANY OF WHOM CONTINUE TO SPEAK THEIR NATIVE LANGUAGE,AND ARE STAFFED BY BI-LINGUAL STAFF WHERE INDICATED. THESE PROGRAMS, WHILE GENERALLY MORE EXPENSIVE, ON A PER MEAL BASIS, DUE TO SPECIAL FOODS COUPLED WITH FEWER MEALS BEING PREPARED,ARE SUCCESSFUL IN ATTRACTING PARTICIPANTS FROM THESE ETHNIC GROUPS, REDUCING ISOLATION AND MAINTAINING HEALTH THROUGH SOCIALIZATION AND THROUGH BENEFITING FROM OTHER SERVICES OFFERED AT THE SITE.

WHILE ETHNIC MEALS MAY ATTRACT ETHNIC PARTICIPANTS, IT IS APPARENT TO ME THAT THE ETHNIC MEALS ARE NOT THE ONLY AND PROBABLY NOT THE MAJOR FACTOR THAT ENCOURAGES ETHNIC PARTICIPATION AT CONGREGATE NUTRITION SITES. KIRSCHNER ASSOCIATES(2)FOUND IN THEIR 1982 NATIONWIDE STUDY OF NUTRITION PROGRAMS THAT THE THREE MOST IMPORTANT VARIABLES RELATED TO MINORITY PARTICIPATION IN NUTRITION PROGRAMS WERE MINORITY REPRESENTATION AMONG STAFF MEMBERS, SITES WHICH HAD SPECIAL ASSISTANCE (SUCH AS CLOTHING, WHEELCHAIRS, ETC.) AVAILABLE TO PARTICIPANTS AND PROGRAMS THAT HAD A HIRING POLICY THAT EMPHASIZED MINORITIES. FROM THIS IT MAY WELL BE THAT STRENGTHENING AND RE-EMPHASIZING AFFIRMATIVE

ACTION HIRING PRACTICES IN THE REAUTHORIZATION OF THE ACT WILL BETTER "SERVE" THE NEEDS OF ETHNIC AND MINORITY PARTICIPANTS THAN THE ETHNIC MEAL ALONE.

NUTRITION EDUCATION, DESPITE THE FACT THAT IS IS NO LONGER PERCEIVED AS A REQUIRED SERVICE IN THE ACT, CONTINUES TO BE AVAILABLE AT MOST (90%) NUTRITION SITES. MOST NUTRITION EDUCATION CAN BE CHARACTERIZED AS "BASIC FACTS ABOUT NUTRITION", I.E., FOOD GROUPS, NUTRITIONAL VALUE OF FOODS, CALOREIS, BALANCED DIETS, VITAMINS AND MINERALS, OBESITY OR "NUTRITIONAL PRACTICES", I.E., FOOD PURCHASING AND FOOD OR MEAL PREPARATION.

THOUGH NOT AS POPULAR AS THE MEAL OR SOCIALIZATION, NUTRITION EDUCATION IS A SIGNIFICANT SERVICE TO ELDERLY PARTICIPANTS. ITS VALUE IN TEACHING PARTICIPANTS COOKING FOR ONE OR TWO PEOPLE, ASSUMING THE "COOKING" ROLE ONCE PERFORMED BY A SPOUSE, DEALING WITH CHEWING OR DIGESTIVE CHANGES, INTERPRETING NEW PRODUCTS IN MEETING MEDICALLY RESTRICTED DIET REQUIREMENTS, OR CREATING A "NEW EXCITMENT" ABOUT THE IMPORTANCE OF NUTRITION IS VITAL TO OPTIMAL HEALTH. ITS IMPORTANCE IS RECOGNIZED BY WE WHO ARE IN DAILY CONTACT WITH ELDERLY PARTICIPANTS AND ITS EMPHASIS SHOULD BE STRENGTHENED IN THE ACT.

MAINTAINING HIGH QUALITY NUTRITION SERVICES IN BOTH CONGREGATE AND HOME-DELIVERED PROGRAMS HAS BEEN A PRIORITY FOR NUTRITION SERVICE PROVIDERS SINCE THE PROGRAM'S INCEPTION. CONGRESS RECOGNIZED THIS NEED EARLY BY REQUIRING BASE LEVEL TRAINING FOR ALL PROJECT DIRECTORS WHEN THE NUTRITION PROGRAM FOR THE ELDERLY WAS INITIALLY FUNDED IN 1973. HOWEVER, SUCH TRAINING HAS NOT BEEN AVAILABLE TO NUTRITION

Service providers for the past eight years. The Older Americans Act does little, in this regard, beyond requiring that all meals meet one third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council (1/3 RDA). Considerable variance exists from State to State in providing Policies and Guidelines for Nutrition Services Operations and Federal Regulatory Guidance is all but non-existent.

In response to this concern, the National Association of Nutrition and Aging Services Programs recently developed and adopted Nutrition Services Program Standards for both Congregate and Home-Delivered Nutrition Programs. These Standards were developed with input from throughout the Aging Network and, in our opinion, are the best available Standards for Nutrition Program Operations. NANASP urges this Subcommittee to include these Standards, via reference, in the pending reauthorizing legislation of the Older Americans Act.

Though testimony was only requested in the areas cited above, it is critical to indicate to this Subcommittee that, while important, these areas are not the only areas of concern to us. A major concern relates to the recent Administration Budget Request and its recommendations regarding reauthorized of the Older Americans Act. As you know the Administration has proposed, among other things, a consolidation of Title III programs into a single grant. If agreed to by Congress, this would, in effect, eliminate the federal mandate for Congregate and Home-Delivered Nutrition Programs for the Elderly. Instead of the separate categorical funding for these nutrition programs, States could choose to spend the money for any aging service program authorized under the Act.

In addition, the Administration proposes to transfer the USDA Cash/Commodity program from the Department of Agriculture to the Department of Health and Human Services and include this amount into the "aging block-grant" to the States. This would end reimbursing Nutrition Projects for meals served. Rather, it would be given to the States on a formula basis, be subject to administrative costs by State and Area Agencies and as a consequence, it would result in a dramatic loss of funding for Nutrition Programs for the elderly.

It is important to point out to this Subcommittee that "block-granting" the Older Americans Act will do little to increase local flexibility. The Older Americans Act is unique in that it requires local planning and decision making already through the mandated aging network of State Units and local Area Agencies on Aging. I strongly urge the Congress to reject any attempts to "block-grant" the Older Americans Act and to continue the USDA Cash/Commodity Program as is with funds distributed to the field based on meals served and that those funds continue to be used only for the provision of meals.

Finally, I would like to request that this Subcommittee advocate for increased appropriations for all services provided through the Older Americans Act. It appears to me that there is something very wrong with our priorities when we would rather spend our limited National Resources on Thermonuclear Weapons that, with God's help, we will never use, rather than on meals and other vital services that, with your help, we need and will surely use.

REFERENCES

(1) GOING HUNGRY IN AMERICA, REPORT BY SENATOR EDWARD M. KENNEDY TO THE COMMITTEE ON LABOR AND HUMAN RESOURCES, UNITED STATES SENATE, 177 PP., DECEMBER 22, 1983.

(2) AN EVALUATION OF THE NUTRITION SERVICES FOR THE ELDERLY, KIRSCHNER ASSOCIATES, INC./OPINION RESEARCH CORPORATION, CONTRACT #105-77-3002, DHHS PUBLICATION NO. (OHDS) 83-20916, 3 VOLUME SET.

Senator **GRASSLEY**. Thank you, Mr. Moyer. Now, Dr. Holt.

Dr. **HOLT**. My name is Peter Holt. I am chairman of the Council on Aging of the American Gastroenterological Association and a spokesman also for the Coalition of Digestive Disease Organizations.

I am testifying not as part of the nutrition establishment, but as a specialist in digestive disease and wish to bring a somewhat different perspective to the subject of providing dietary help to the aging.

I would like to make three points today. Undernutrition and malnutrition occur in a large segment of our aging population. Such malnutrition either produces illness by itself or prolongs or complicates other diseases from which the elderly suffer.

However, simply providing extra food may not be a sufficient answer for their nutritional needs. The food we eat needs to be digested and absorbed from the intestine into the body before the calories and other nutrient components can be utilized by the body tissues. This process of digestion and absorption occurs in the intestine, the digestive system, which in older persons does not function as efficiently as in the young.

Recognition of maldigestion and malabsorption thus become crucial for planning food supplementation programs which will produce the greatest benefits. For example, it has been clearly shown that the digestion and absorption of carbohydrates from the diet are decreased with advancing age. If an individual consumes carbohydrates in excess of what the intestine can digest and absorb, then not only does the body not benefit, but unpleasant abdominal symptoms can result.

In addition, the intestine is known to adapt rapidly, either from meal to meal or from day to day, and this process of adaptation is almost certainly impaired with advancing age.

For these reasons we need to be more precise in defining food supplements in the elderly than for the young.

Second, I should like to mention nutritional disorders of great medical importance to the elderly which are initiated by changes in the intestine.

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I will give two specific examples. Osteoporosis, loss of bone calcium, occurs universally in the elderly. Osteoporosis leads to frequent and easy bone fractures, frequently which are painful and unpleasant and adds greatly to our health care costs. It is now recognized that reduced intestinal absorption of calcium from food is an important component of osteoporosis.

Although supplementation of the diet of the elderly with calcium containing foods is advocated and is very helpful, a better approach will be to control the absorption of this important mineral at the intestinal level. This should be possible since we normally do not absorb most of the calcium which is present in the diet.

Another nutritional disorder in some elderly persons is reduced body stores of folic acid, a crucial B vitamin. Folic acid deficiency results in several medical disorders. The weight of present evidence suggests that the abnormality which leads to folic acid depletion in the elderly is an impairment of the digestion in the intestine of the folate that is present in complex forms in foods.

If this is the case, then the provision of additional foods containing such complex folate is not an approach which will effectively treat the problem.

Third, it is appropriate to ask whether dietary programs can play a role in preventing digestive diseases of the elderly. In advanced age, diseases of the colon are common, are disabling, and are costly.

The balance of nutrients in a diet during a lifetime of eating habits, currently is believed to influence the appearance of colon cancers late in life. The development of diverticulosis and diverticulitis, which are so frequent later in life, may be abolished or delayed by changing the low residue diet that is so commonly eaten today in Western countries and by increasing the content of some fiber containing foods in the diet.

Finally, constipation is almost universal in the elderly and results in much discomfort. It, too, can be alleviated by judicious dietary adjustment.

Mr. Chairman and members of the committee, I have tried to take select areas that the digestive disease community feel are important to consider in the development and expansion of the very important nutritional services for the elderly, which are provided under title III legislation of the Older Americans Act.

An understanding of the contribution of the digestive system to undernutrition and its dietary management and recognition that changes occur in the intestine in advanced age are needed to make dietary supplementation programs nutritionally cost effective.

We hope that we can play a role in the development of that information.

Thank you.

[The prepared statement of Dr. Holt follows:]

Coalition of
Digestive
Disease
Organizations

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Suzanne Rosenthal
Chairman

Louis Raffio
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TESTIMONY OF

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MANHATTAN, NEW YORK
CHAIRMAN , COUNCIL ON AGING
AMERICAN GASTROENTEROLOGICAL ASSOCIATION

ON BEHALF OF
THE

COALITION OF DIGESTIVE DISEASE ORGANIZATIONS
295 MADISON AVENUE, RM. 519
NEW YORK, NEW YORK

BEFORE THE

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES

CONCERNING

TITLE III OF THE OLDER AMERICANS ACT

FEBRUARY 24, 1984

My name is Peter R. Holt; I am Chairman of the Council on Aging of the American Gastroenterological Association and a spokesman also for the COALITION of DIGESTIVE DISEASE ORGANIZATIONS. I am testifying not as part of the nutrition establishment, but as a specialist in digestive disease, and wish to bring a somewhat different perspective to the subject of providing dietary help to the aging. I would like to make 3 points in my testimony.

Undernutrition and malnutrition occur in a large segment of our aging population. Such malnutrition either produces illness by itself or prolongs or complicates other diseases from which the elderly suffer. However, simply providing extra food may not be a sufficient answer for their nutritional needs. The food we eat needs to be digested and absorbed from the intestine into the body before the calories and other nutrient components can be utilized by the body tissues. This process of digestion and absorption occurs in the intestine (the digestive system) which, in older persons, does not function as efficiently as in the young. Recognition of maldigestion and malabsorption thus becomes crucial for planning food supplementation programs which will produce the greatest benefits. For example, it has been clearly shown that the digestion and absorption of carbohydrates from the diet are decreased with advancing age. If an individual consumes carbohydrates in excess of what the intestine can digest and absorb, then not only does the body not benefit, but unpleasant abdominal symptoms can result. The intestine is known to adapt rapidly, either from meal to meal, or from day to day and this process of adaptation is almost certainly impaired with advancing age. For these reasons, we need to be more precise in defining food supplements in the elderly than for the young.

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Secondly, I should like to mention nutritional disorders of great medical importance to the elderly which are initiated by changes in the intestine. I will give two specific examples.

Osteoporosis (loss of bone calcium) occurs universally in the elderly. Osteoporosis leads to frequent and easy bone fractures, the treatment of which adds greatly to our health care costs. It is now recognized that reduced intestinal absorption of calcium from food is an important component of osteoporosis. Although supplementation of the diet of the elderly with calcium containing foods is advocated and is very helpful, a better approach will be to control the absorption of this important mineral at the intestinal level. This should be possible since we normally do not absorb most of the calcium which is present in the diet.

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The development of diverticulosis and diverticulitis, which are so frequent later in life, may be abolished or delayed by changing the low residue diet that is so commonly eaten today in Western countries and by increasing the content of

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some fiber-containing foods in the diet. Finally, constipation is almost universal in the elderly and results in much discomfort. It too can be alleviated by judicious dietary adjustment.

Mr. Chairman and members of the Committee, I have tried today to select areas that the digestive disease community feel are important to consider in the development and expansion of the very important nutritional services for the elderly which are provided under Title III legislation of the Older Americans Act. An understanding of the contribution of the digestive system to undernutrition and its dietary management and recognition that changes occur in the intestine in advanced age are needed to make dietary supplementation programs nutritionally cost-effective. We hope that we can play a role in the development of that information.

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Dr. Peter R. Holt
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Dr. Holt graduated the University of London in 1954, took his postgraduate training in Gastroenterology at the University of Massachusetts General Hospital and Harvard Medical School from 1959-1961. He has been at Columbia University since that time. He has contributed extensively to the medical literature in the field of intestinal absorption, nutrition and the effects of aging upon the gastrointestinal tract. Currently, Dr. Holt is the Chairman of the Council on Aging of the American Gastroenterological Association.

Senator **Grassley**. Thank you very much. I have probably more questions than I can take time to ask, but we are going to start out and see how it works out.

I would like to direct first to Mr. Moyer and to Ms. Greene the fact that in Mr. Moyer's testimony you seem to be saying—I guess I have a direct quote here, "Nutrition education is no longer perceived as a required service in the act" though the act mentions nutrition services in many places in title III.

So my question to both of you: is not education a part of those services?

Well, you can start out, Ms. Greene, if you want to.

Ms. **Greene**. Nutrition education is stated in part C of title III nutrition services after the language about the nutrition projects providing meals 5 days a week. It specifies nutrition education "may" be included. That is weak, and we would like it strengthened to say "shall be included," because there is no mandate to have nutrition education.

Now, nutrition education could be considered a supportive service. We are also saying that it is not mandated.

Senator **Grassley**. OK. Mr. Moyer.

Mr. **Moyer**. I simply reinforce that. The word "may" has made possible throughout the country options for inclusion or exclusion of nutrition education as a service.

Senator **Grassley**. OK. Well, then has there been an evolution throughout the tenure of the Older Americans Act where—because you use the words "no longer perceived as a required service."

In other words, you are saying that early on it was perceived as a required service even though it was not mandated.

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Mr. **Moyer**. It was mandated.

Ms. **Greene**. It was mandated.

Senator **Grassley**. It was mandated. When was that change made, then?

Mr. **Moyer**. The 1978 amendments took that—took the eight mandated services out that were part of the congregate nutrition program initially.

Senator **Grassley**. The next question is for you, Ms. Greene. How many nutrition and dietary experts are presently involved in the operation of title III programs?

Ms. **Greene**. I could get that answer. I do not have the number, but I do know we have them in regional offices, and State offices. Many area agencies have nutritionists that consult about their programs.

And we have them in the nutrition projects. I do not now have a number, but I could get that for you.

Senator **Grassley**. Well, it would be perfectly all right if you would submit that to us in writing within 15 days.

Peg, does your organization, the National Association of Meal Programs, receive any Older American Act funding presently earmarked for home delivery meals?

Ms. **Sheeler**. You mean to run the association itself?

Senator **Grassley**. No.

Ms. **Sheeler**. You mean our home delivered meal program?

Senator **Grassley**. Yes.

Ms. **Sheeler**. Oh, yes. A substantial number of them receive Older American Act money. We have all types of programs. Some receive Older American Act funds. Some do not receive any public funds from any organizations at all. They are strictly voluntary. They raise the funds in their own community to offer their Meals on Wheels programs. And some of them are a combination of Older Americans Act funds, United Way funds, Catholic Charities, as well as voluntary contributions.

Senator **Grassley**. What percentage of that $62 million would your service receive; do you know?

Ms. **Sheeler**. I honestly cannot answer that.

Senator **Grassley**. Do you think you could get that and submit that in writing?

Ms. **Sheeler**. Yes.

Senator **Grassley**. OK. I want to read some sections here, but I will ask the question before I read so you know what I am leading to. I want to know whether or not these sections give your organization the protection against the activities that your testimony referred to.

And section 307(A)(10) of title III reads that each State plan:

> Provided that no supportive services, including nutrition services, will directly provided by the State agency or an area agency on aging except where in the judgment of the State agency provisions of such services by the State agency or an area agency on aging is necessary to assure an adequate supply of such services.

And then I want to quote from section 307(A)(13)(h):

> That each area agency will give consideration where feasible in the furnishing of home delivered meals to the use of organizations which have demonstrated an ability to provide home delivered meals efficiently and reasonably.

And then some words are skipped.

> And that funds made available under this title will not b[illegible]ed to supplant funds from non-Federal sources.

Ms. Sheeler. I think the problem is that when a small, home delivered meals program that is primarily dependent upon private contributions, first of all, they are not totally aware and this is a problem that we have had ever since we have had the Home Delivered Meals Act; that is one problem. The other problem is that many times the interpretation at the State and local level is a little bit different than you would anticipate and I would interpret in the act. And sometimes there is no way to redress this.

And we as a national sometimes do not hear of these until after the fact, until after the home delivered has—there is another home delivered in the exact same community. And then these smaller operations will then contact the national association.

At that point in time it is almost too late to try to do anything.

Senator Grassley. I suppose as a practical matter it is impossible for your national organization to maintain enough liaison with your locals. I mean, what about through—do you have the advantage of a newsletter where——

Ms. Sheeler. We do that. Some of these organizations that we hear about did not even opt to belong to any of our national organizations. So that is another disadvantage.

Senator Grassley. OK. Now, I would like to go to Mr. Moyer, but before I go back to asking you a different question, I just want to finalize, which I did not do in the first question. Then what you are saying is you would like to have the language in this reauthorization go back to the pre-1978 language in regard to education, right?

Mr. Moyer. Yes; I would like to see nutrition education required. Currently under 3(C)(1) the only services that are possible to fund are outreach, meals, and nutrition education.

Senator Grassley. OK. Well, from a technical standpoint, then, are you talking about just changing "may" to "shall" or are you talking about going beyond that?

Mr. Moyer. I would love to return to title VII with the mandated services, but being a realist, changing the "may" to "shall" would be appropriate.

Senator Grassley. I should probably ask you too, Ms. Greene, to comment on my latest, more specific question.

Ms. Greene. Well, I would like "shall" instead of "may," and if possible, that consideration be given also to this service being provided by dietitians and nutritionists or supervised by a dietitian, so that whoever is providing the service we can make sure it is quality service.

Senator Grassley. Yes; and I should say that I did understand from your testimony that you were in fact going beyond what my question would indicate. And I appreciate your position as well.

Mr. Moyer, what percentage of the 13,000 nutrition sites does your organization serve?

Mr. Moyer. Sir, there are approximately 1,300 total projects in the country with 13,000 nutrition sites. We have as a membership about 450 of those projects. So, 40 percent, maybe.

Senator **Grassley**. Forty percent. Is it the policy of your organization and its members to cooperate with volunteer groups in programs such as the National Association of Meals Programs, whose purpose is the delivery of congregate and home delivered meals also.

Mr. **Moyer**. Yes.

Senator **Grassley**. In its nutrition education programs, does your organization interact with the American Dietetic Association in any way so as to provide the most relevant data on nutritional practices to your elderly participants?

Mr. **Moyer**. Yes.

Senator **Grassley**. Now, Dr. Holt—and I do not mean to preclude any of you from responding to each other's questions if you want to, but I am now to Dr. Holt.

You have included in your testimony a very informative folder on diseases of the digestive tract and we want to thank you for that. Can you tell us how widely this information is being distributed?

Dr. **Holt**. The information package is currently available through the National Digestive Disease Education and Information Clearinghouse, which is a Federal initiative and anybody who wants it can have it. That's as far as the distribution goes.

Senator **Grassley**. Could the Older Americans Act network be a part of its distribution?

Dr. **Holt**. Yes. We would be happy indeed to work with the Administration on Aging to work out a way in which such information can be distributed.

Senator **Grassley**. OK. Your testimony seems to indicate that a balanced diet is not only—is not the only requirement for older individuals, that food supplements are the key to a healthier digestive system in the elderly.

Can these reasonably be a part of nutrition sites and an area of their concern?

Dr. **Holt**. Yes, I believe so. As the information develops for improving the specific nutritional needs of the elderly, the sites can be of assistance both in providing the specific supplements and in providing the educational programs that lead to the application of this information.

Senator **Grassley**. Would your organization, then, work with the Administration on Aging and if you could and you need a go between, I would be glad to encourage dialog.

Dr. **Holt**. We would be delighted to do so.

Senator **Grassley**. Thank you very much. I want to say thank you for all your testimony and please continue to be in contact with us over the next 6 weeks as this committee and the Senate as a whole works on this legislation. Thank you.

Dr. **Holt**. Thank you.

Senator **Grassley**. I would now like to call our last witness and he is Alfred A. Delli Bovi. He is Deputy Administrator of the Urban Mass Transportation Administration. Funds appropriated under the Urban Mass Transportation Act of 1964 flow to States for capital investment in vehicles, parts, and other items aiding in the transportation services to older Americans.

The DOT witness will discuss how these funds are earmarked to the States. And I would like to have you proceed, as I suggested to the other people. I want to thank you for coming and being patient while all the other witnesses testified.

STATEMENT OF ALFRED A. DELLI BOVI, DEPUTY ADMINISTRATOR, URBAN MASS TRANSPORTATION ADMINISTRATION

Mr. Delli Bovi. Thank you very much, Mr. Chairman. Thank you for inviting me here this morning to discuss the programs administered by the Urban Mass Transportation Administration, which assists in meeting the transportation needs of the elderly. We will submit for the record and have submitted for the record the formal statement, and I will summarize now.

Since 1970 with the addition of section 16 of the UMT Act, we have had a mandate to address the transportation needs of elderly and handicapped persons in all of our programs.

As stated in section 16 of our act, it is national policy that the elderly and the handicapped have the right to use mass transportation facilities and services. Our only program designed exclusively for the elderly and handicapped is the program authorized under section 16(b)(2) of the Urban Mass Transportation Act. I like to think of it as one of our happy programs because under it UMTA makes capital grants to private, nonprofit corporations and associations for the specific purpose of assisting them in providing transportation services that meet the special needs of the elderly and the handicapped.

I call it a happy program because it is result oriented. We in UMTA enjoy seeing the people who need the transportation services delivered to the places they want to go to. And it is very cost effective, I might add.

We have developed an administrative formula which allocates most of the section 16(b)(2) funds according to elderly and handicapped population. But it does incorporate a base level that guarantees a certain minimum for each State. Each year these section 16(b)(2) funds are distributed according to that formula to the State agencies which are designated by the Governors in each of the States to administer the program.

Since the beginning of fiscal year 1975 UMTA has allocated more than $225 million to the States under this program and in the current year we are allocating $26.1 million. UMTA provides a Federal share of 80 percent for the capital expenses and the remaining 20 percent comes from State and local funds.

UMTA does not provide operating assistance to the recipients; however, a number of agencies within the Department of Health and Human Services, most notably the Administration on the Aging, significantly assist local recipients in meeting their operating expenses.

UMTA is committed to the section 16(b)(2) program and is pleased with its success. We have recently published guidelines which significantly streamline our procedures. The new section 16(b)(2) circular which was signed by our Administrator, Ralph Stanley, on February 16, 1984, is a major step forward for the program because for the first time in the program's history, the State agencies administering this program will have comprehensive, clear, and concise regulations and guidelines all available in one document.

Coordination between our program and other Federal programs in providing transportation to the elderly and the transportation disadvantaged is, however, the key to meeting the mobility needs of the elderly.

To facilitate the State-Federal relationship, UMTA has established a State program division in our headquarters to consolidate within one office all State administered transit programs.

However, we realize that the needs of the elderly can best be met by coordination at all levels. And toward that end in July of last year, we entered into a working agreement with the Administration on Aging concerning transportation programs. The broad goals of this working agreement are to foster the coordination of public mass transit service and resources with those transportation services operated and sponsored by local social service agencies.

Also in October of this year the Administration on Aging and UMTA will jointly sponsor a conference focusing on ways the two agencies together and their respective grantees at the State and local level can more effectively coordinate the use of these resources to the people who need them.

In addition to the unique and specific section 16(b)(2) program, UMTA and the Department of Transportation do require all of our grant recipients to address the transportation needs of the elderly and the handicapped in accordance with section 504 of the Rehabilitation Act of 1973.

That concludes my remarks. I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Delli Bovi follows:]

STATEMENT OF ALFRED A. DELLI BOVI, DEPUTY ADMINISTRATOR OF THE URBAN MASS TRANSPORTATION ADMINISTRATION, BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES, SUBCOMMITTEE ON AGING OF THE UNITED STATES SENATE ON FEBRUARY 24, 1984

Mr. Chairman, Members of the Subcommittee. Thank you for inviting me here this morning to discuss programs administered by the Urban Mass Transportation Administration (UMTA) which assist in meeting the transportation needs of the elderly.

I should start out by saying that since 1970, with the addition of section 16 of the UMT Act, UMTA has had a mandate to address the transportation needs of elderly and handicapped persons in all of its programs. As stated in section 16, it is national policy that elderly and handicapped individuals have the same rights as other persons to use mass transportation facilities and services.

The only program designed exclusively for elderly and handicapped persons is the program authorized under section 16(b)(2) of the Urban Mass Transportation Act of 1964, as amended.

Section 16(b)(2) permits UMTA to make capital grants "to private non-profit corporations and associations for the specific purpose of assisting them in providing transportation services meeting the special needs of elderly and handicapped persons."

The section 16(b)(2) program resulted from 1973 amendments to the UMT Act and was intended to supplement the section 3 capital grant program, which at the

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time was UMTA's primary resource for meeting the transportation needs of elderly and handicapped persons.

We have developed an administrative formula which allocates most of the section 16(b)(2) funds according to elderly and handicapped population and which incorporates a base level of funding for each State. Each year, section 16(b)(2) funds are distributed according to that formula to State agencies that administer the program. Since the beginning of fiscal year 1975, UMTA has allocated more than $225 million to States under the section 16(b)(2) program including $26.1 million for fiscal year 1984. While some State agencies have not distributed all of the funds allocated to them, State agencies have distributed the vast majority of these funds to approximately 1000 private non-profit corporations per year. Private non-profit corporations have used most of these funds to purchase vehicles and related equipment which they use for special transportation purposes.

UMTA provides a Federal share of 80 percent for section 16(b)(2) capital expenses. The remaining 20 percent comes from State and local funds. UMTA does not provide operating assistance to section 16(b)(2) recipients. However, a number of agencies within the Department of Health and Human Services, most notably the Administration on Aging, significantly assist section 16(b)(2) recipients in meeting their operating expenses.

UMTA is committed to the section 16(b)(2) program and is pleased with its success. We have recently published guidelines which significantly streamline section 16(b)(2) procedures. The section 16(b)(2) circular, which was signed

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by UMTA Administrator Ralph L. Stanley on February 16, 1984, is a major step forward for the program. For the first time in the program's history, the State agencies administering the program will have a comprehensive, clear, and concise set of program and procedural guidance available in one document.

The circular significantly alters the grant approval process. State agencies will no longer submit applications for individual projects to UMTA for approval. Instead, State agencies will review and approve individual project applications from private non-profit corporations for consolidation into a program of projects which these agencies will submit to UMTA for our approval. In addition to streamlining the grant approval process, this will give State agencies increased responsibility for program management.

Coordination between the section 16(b)(2) program and other Federal programs providing transportation to the elderly or other transportation disadvantaged individuals is the key to meeting the mobility needs of the elderly. To facilitate the State-Federal relationship, UMTA has established a State Programs Division in our Headquarters Office to consolidate within one office all "State administered" transit programs.

However, we realize that the needs of the elderly can be best met by coordination at all levels. Towards this end, UMTA in July 1983 entered into a working agreement with the Administration on Aging concerning transportation programs. The broad goals of the working agreement are to foster the coordination of public mass transportation services and resources with those transportation services operated by or sponsored by social service agencies.

Specifically, during fiscal year 1984, UMTA will continue to implement programs that improve the access of older persons to public and specialized transportation systems. The Administration on Aging has agreed to encourage State and area aging agencies to continue to support operating assistance for projects which receive capital assistance from UMTA.

Also, in October of this year, AOA and UMTA will jointly sponsor a conference focusing on ways the two agencies and their respective grantees at the State and local level can more effectively coordinate resources and services.

In addition to the unique and specific section 16(b)(2) program, UMTA and the Department of Transportation do require all UMTA grant recipients to address the transportation needs of the elderly and handicapped in accordance with section 504 of the Rehabilitation Act of 1973. The current interim final rule in this area allows recipients to meet these needs in a variety of ways. On September 8, 1983, the Department of Transportation issued a notice of proposed rulemaking to amend the existing interim final rule. The proposed rule provides more specific requirements for meeting the transportation needs of elderly and handicapped persons. The proposed rule would: (1) establish minimum criteria that UMTA recipients must meet for the provision of transportation services to elderly and handicapped persons; (2) establish procedures for the Department of Transportation to monitor recipients' compliance; and (3) ensure that elderly and handicapped persons, and organizations representing them, have an opportunity to comment on a recipient's compliance plan. More than six-hundred comments have been received, and the Department is now reviewing them before issuing a final rule.

That concludes my remarks and I would be pleased to answer any questions you may have.

Senator **Grassley**. I think you have answered all my questions but one. It is a very short one. Do you—as you can best recall dealing with the various States and other units you deal with, is it the State DOT's that get most—administer most of these funds?

Mr. **Delli Bovi**. Generally. It is up to the Governor in each State to designate the agency, and in most States the agency designated is the State Department of Transportation. But that decision rests with the Governor in each State.

Senator **Grassley**. OK. But you think it has turned out that that is the case?

Mr. **Delli Bovi**. In the greatest majority of cases, it is the State DOT.

Senator **Grassley**. OK. Well, since you have addressed the points that we had concern of and no other parts of your testimony raised any questions, I thank you very much and look forward to working with you. I have had an opportunity in the 9 years, both in the House and the Senate now that I have been on aging committees to be very concerned about transportation of elderly in rural areas where really the programs are not of much value unless we are able to get people there.

I held several hearings in my own State on that specific subject, and I am glad to see that things are working in that direction.

Thank you very much.

Mr. **Delli Bovi**. Thank you very much, Senator.

[Additional material supplied for the record follows:]

FRAC
FOOD RESEARCH AND ACTION CENTER

Nancy Amidei
Executive Director

Statement of the

Food Research and Action Center

(For inclusion in the proceedings of the
February 24, 1984 hearing of the Senate
Committee on Labor and Human Resources,
Subcommittee on Aging.)

1319 F STREET, N.W. #500 • WASHINGTON, D.C. 20004 • (202) 393-5060

The Food Research and Action Center (FRAC) is a public interest law firm and advocacy center working to alleviate hunger and malnutrition in the United States. Because of our orientation, we would like to comment on the nutrition programs authorized by the Older Americans Act.

Let us begin by saying that we strongly support the Congregate and Home-Delivered Meals Programs and believe that the basic structure under which they operate is a good one. A recent evaluation of these programs conducted for the Department of Health and Human Services by Kirschner Associates, Inc. documented the positive benefits of program participation. The study reports that, "[i]ncreased nutrient intake is directly related to participation in the congregate and home delivery services."[1]

It is well known that adequate nutrition plays an important role in the maintenance of good health with advancing age. The service priorities addressed by the Older Americans Act reflect a recognition that a multiplicity of factors may be barriers to adequate nutrition among the elderly. We wholeheartedly support continued access to these programs by all older persons.

We do, however, have specific concerns regarding the low-income elderly and the minority elderly who are tragically overrepresented among the ranks of the poor. For these elders, access to adequate nutrition can make a significant difference in their ability to survive, and participation in OAA programs can greatly enhance their quality of life.

The problem of hunger in America has received widespread recognition in recent months. One of the most painful phenomena which has come to our attention is the fact that soup kitchens and emergency food pantries have begun to serve a different clientele; numerous reports have documented that senior citizens are now more frequent users of these services.

A recent study conducted by Social and Scientific Systems, Inc. for the United States Department of Agriculture, in answer to the question, "Who are the recipients of emergency food...?" responded that they are, "...no longer simply the chronically destitute, infirmed or unemployable [but]...today... senior citizens... are standing...at food pantries."[2]

These are not just the mentally disabled, or those with problems related to alcohol use. These are simply people who have grown old without adequate resources to care for themselves. Reductions in federal spending in a host of social programs have resulted in many elders stretching their resources to the limit, and then deciding whether to pay for heat, food or other necessities.

We are well aware that the programs under the Older Americans Act are not designed to be able to meet all the needs of an individual, and are not able to serve all who might benefit from service. But we implore you to consider the plight of the most needy elders and respond by expanding nutrition services to reach a greater number of these persons. We must underscore, in this context, that it would be detrimental to try to target resources to the low-income by taking service away from present recipients. We believe the only reasonable approach is to provide additional funds to expand services.

An extensive report compiled recently in Chicago found that, in that city, fewer than one in five elderly persons living below the poverty line were served by congregate or home-delivered meals.[3] This same study questioned a number of emergency food service providers: one pantry reported providing food for 150 to 160 people over 65 each month; another said the number of food bags given to the elderly poor has tripled in the last three years. (page 83)

Sources in Chicago also found that while the number of congregate meals served between 1979 and 1981 increased seven percent, the percentage served to those in poverty only increased 1.3 percent, and while the number of home-delivered meals increased 122 percent between 1979 and 1981, the percentage served to those in poverty climbed only 4.8 percent.

Chicago is not unique. Numerous other cities have reported emergency food facilities serving the elderly in increasing numbers;* other locales report only small percentages of the elderly poor receiving congregate and home-delivered meals. Nationwide there are 4.9 million people aged 60 and above with incomes below the poverty line (1982 Census), but only a little more than 2 million "low income" elderly receive nutrition services from OAA programs -- less than 43 percent of persons who are likely to be in great need of these programs.**

We are also concerned about information reported in the Kirschner study which shows that, "[r]ecruitment is less extensive than in the past and less emphasis is placed upon enrolling priority elderly persons. Most congregate sites are operating at or near capacity."[5] The most dramatic shift has been away from recruitment of the low-income elderly.

We know that the Congregate and Home-Delivered Meals Programs provide participants with at least one-third of their recommended daily allowances of calories and essential nutrients. For the poor, who were shown to have lower intakes of key nutrients, Kirschner indicated that, "[c]onsumption of a program meal elevated dietary intakes among poorer elderly respondents so that it was comparable to intakes of more affluent respondents."[6]

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* For example, see "Still Hungry: A Survey of People in Need of Emergency Food," Food Research and Action Center, November, 1983, Appendix B.

** Figures vary regarding the number of low-income people served. The AoA reports 61% of congregate meals and 67% of home-delivered meals were served to the "economically needy" in FY 1982. The Kirschner report indicates only 52% congregate and 64% home-delivered meal participants to be "low income," despite using a definition of low income which is higher than the poverty line ($6,000 in 1981).

No such evidence exists as to the nutritional quality of meals served in soup kitchens. Also, soup kitchens do not provide the supportive atmosphere and related services available in OAA programs. Clearly, the Title III programs are a far superior means of serving the elderly.

In testimony presented before the Subcommittee on Aging of the Senate Committee on Labor and Human Resources, Dr. Robert Binstock reported that an effective means of targeting resources to the low-income elderly would be to allocate federal funds, "on the basis of the number of low income older persons in each state."[4] Unfortunately, in order to achieve such a distribution without reducing allocations to any state would require about $700 million more, or a 130 percent increase in Title III appropriations, according to Binstock.

His testimony indicates that some initiative at the federal level could help allocate funds to the low-income, but only with the infusion of increased funding could it be done without great disruption. We recommend additional federal funds which would exist specifically to address the documented, un-met needs of low-income seniors. Such funds would be intended to increase services by opening new meal sites in low-income areas, expanding services in locations already accessible to the poor, and increasing home-delivered services to low-income seniors.

It is crucial that such expansion become a regular component of OAA funding so that these expanded services could be maintained. In accordance with current law, no means testing should be permitted. Rather, self-declaration of need, site location and other measures could be used to assess low-income status.

With regard to targeting attempts, we would emphasize that federal guidance and enforcementare necessary. A shift to local responsibility for targeting could result in unfortunate gaps in targeting of services in some locales.

A related issue is that of voluntary contributions in the OAA. During the past three years, the Administration on Aging has placed an increased emphasis on the solicitation of voluntary contributions in senior meals programs. We believe the practice of allowing participants to contribute toward the cost of meals is a valid one, but only so long as such contributions remain truly voluntary.

Service providers who have been unduly pressured to procure additional contributions may, in turn, overemphasize the need for donations to their participants. In some cases low-income seniors have dropped out of much-needed meal programs due to embarrassment at their inability to pay. It is important that the Act emphasize that such contributions be strictly voluntary, confidential, and that no person may be denied service for failure to contribute.

Furthermore, the Administration has implied that increased contributions could be used to maintain service levels in the face of federal reductions in funding. We believe such a policy would contradict the Act which states that, "such charges will be used to increase the number of meals served by the project involved...."[7] It is our understanding that there is no justification for using participant contributions as a rationale for decreased federal support.

Finally, there has been talk of modifying the method of funding of OAA programs by doing away with separate allocations for Congregate Meals, Home-Delivered Meals, Supportive Services, and State Administration. We believe that this would be a serious mistake.

Separate funding for nutrition programs insures that there will be at least a minimum amount of money spent for these vital services. Because the provision of meals is so important, it would be unfortunate if the OAA programs became oriented away from nutrition services. The elderly have special nutritional needs which are superbly addressed by existing programs. We hope distinct funding and authorization for nutrition programs will be retained.

References

1. Kirschner Associates, Inc., "An evaluation of the Nutrition Services for the Elderly," Volume I, page 7, May, 1983.
2. Social and Scientific Systems, Inc., "A Report on Nine Case Studies of Emergency Food Assistance Programs," page 157, May, 1983.
3. Eighth Day Center for Justice et. al, "Chicago Hunger Watch Report," page 82, October, 1983.
4. Robert H. Binstock, Ph.D., testimony on Targeting Scarce Resources Under the Older Americans Act, page 8, November 15, 1983.
5. Kirschner Associates, Volume I, page 5.
6. Kirschner Associates, Volume II, page IV-8.
7. Older Americans Act, Section 307(a)(13)(C)(ii).

AMERICAN BAR ASSOCIATION

STATEMENT OF
ERICA F. WOOD

on behalf of the
AMERICAN BAR ASSOCIATION

submitted to the
SUBCOMMITTEE ON AGING
of the
COMMITTEE ON LABOR & HUMAN RESOURCES
of the
UNITED STATES SENATE

March 2, 1984

Mr. Chairman and members of the Subcommittee, I am Erica Wood, a member of the Commission on Legal Problems of the Elderly. I appear before you today at the request of Wallace D. Riley, the President of the American Bar Association, to present the Association's views with respect to the reauthorization of the Older Americans Act. I am the Chairperson of the Commission's Subcommittee on the Delivery of Legal Services.

The American Bar Association's Commission on Legal Problems on the Elderly is a fifteen-member, interdisciplinary body including practicing attorneys, legal educators, gerontologists, state government officials, elderly law specialists and senior citizen advocates. One of the Commission's six priority areas is the provision of legal services. It seeks to promote the development of accessible, high quality legal resources for older persons; and in particular to generate private bar efforts to supplement public programs with pro bono, reduced fee and community legal education projects. The Commission maintains that the most effective approach for providing adequate legal representation and advice for needy elderly is through the combined efforts of a strong Legal Services Corporation, a strong Older Americans Act program, and the private bar. The comments below focus on ways to maintain and enhance the legal services sections of the Older Americans Act.

Legal Services As An Access Service. Legal services are important because they help needy older persons--who may often be

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vulnerable, frail, or with limited mobility--to secure access to other services, and to basic rights and benefits to which they are entitled. The elderly are often confronted by complex, rapidly changing laws and regulations which govern their quest for food, housing, and decent health care. Moreover, they want and deserve to enjoy the benefits for which they have been working and paying taxes all their lives. If they are unfairly excluded from such benefits, they may need a representative who knows the laws, knows how to present problems to the proper person or agency, knows how to compile the facts and discuss the problem persuasively, and negotiate a solution. Thus, legal assistance is an integral and necessary component of a social service system for needy older Americans.

A 1981 White House Conference on Aging Technical Committee report succinctly expressed the critical role of legal services for older Americans:

> The term 'equal justice' under law applies to all citizens, regardless of age. For the elderly, legal services take on an added dimension, for it is the primary vehicle by which the equitable and efficient delivery of services is ensured. Consequently, legal services can be considered a gateway to improving quality of life. (WHCoA Executive Summary of the Technical Committee on Physical and Social Environment and Quality of Life, p. 10.)

The Final Report of the White House Mini-Conference on Legal Services for the Elderly (January 29-30, 1981) observed:

> Problems of entitlement, procedure, contractual obligation, and simply pushing through the red tape of a bureaucracy, are matters of which legal services can be of great help to the elderly. A legal representative has the skills and knowledge to understand and seek a range of remedies, to secure full access to social services for older Americans . . .. By reaffirming that an individual does have rights, legal services particularly promote the individual's self-respect and dignity.

Given, then, that legal services are vital in assuring needy older persons their basic rights and a full range of other services, how can they best be provided through the Older Americans Act?

Continued Priority on Legal Services. In 1978, Congress designated legal services as one of three priority services under the Older Americans Act. In the 1981 Amendments, Congress specified that each area agency on aging "provide assurances that an adequate proportion" of its Title IIIB social services funds is expended for the priority services, including legal services, and that "some funds" be expended for each category of service. (Sec. 306(a)(2)).

This federal directive is a minimal one. It leaves both the nature and level of services to the discretion of the area agency on aging, thus encouraging variety and creativity in funding and programming. In FY-82, about 5.8% of Title IIIB social services funds at the local level went for legal services. This enabled thousands of older persons to receive legal assistance from specialized legal service projects for the elderly throughout the country. Most of this assistance consists of legal representation and advice to individuals, followed by information and referral, outreach, and community education.

Through Older Americans Act programs, attorneys and paralegals can do the kind of substantial, regular outreach needed to surmount the transportation, mobility and communication problems of many elderly; and develop expertise in areas of law specifically affecting the aged, such as Social Security, Medicare, pensions, and age discrimination. Moreover, about one-quarter of all elderly are "near-poor", and live below 125 percent of the poverty level. Many of these elderly have incomes above Legal Service Corporation program eligibility standards, yet cannot afford the customary fees charged by private attorneys. Title IIIB programs, focused on those "in greatest social or economic need," have begun to fill this service gap.

Many Title IIIB Older Americans Act legal programs work closely with private bar programs. For example, in Memphis, Tennessee, the Title III program and the Young Lawyers Section of the bar have developed a pro bono program through which private attorneys volunteer their services to the aged. In Hartford, Connecticut, the Title III program has provided training and assistance to attorneys in the law department of the Aetna Life and Casualty Company who are giving regular pro bono assistance to senior citizens. In Boston, Massachusetts and in Mississippi, Title III funds support special outreach to older persons as part of the bar association's volunteer lawyers program. In Kansas, the Douglas County Bar Association and the Jayhawk Legal Services for Senior Citizens project have worked together in the Assistance for Elderly Indigents Program, through which local lawyers have begun to volunteer their services for low-income older persons. In North Carolina, Missouri, and other states, Title III funds have assisted bar asociations in the production of Senior Citizens Handbooks--widely distributed, large-type publications concerning law and programs affecting senior citizens in the state. Indeed, the Older Americans Act states that area agencies on aging must "attempt to involve the private bar." (Sec.2307(a)(15)(A)(iii)). The ABA is seeking to foster such effective private-public sector relationships throughout the country.

The statutory priority has been a crucial catalyst in increasing legal resources for older Americans. In April, 1981, the Association's Board of Governors adopted a resolution urging that the Older Americans Act of 1965, as amended, be reauthorized and that it continue to place a high priority on the delivery of legal services to the needy elderly. The ABA now reiterates the value of the priority, which recognizes the significance of legal services and causes area agencies to closely examine local legal needs and ways to meet them.

Despite the legal services priority, some area agencies are still without a legal services provider. This, coupled with the loss of or severe cutbacks in Legal Services Corporation programs in many areas, could leave some older Americans subtantially without legal services--and without an opportunity to obtain equal justice under our legal system.

Strengthening of Waiver Provision. Section 306(b) of the Older Americans Act allows area agencies on aging to waive the requirement of spending funds on a priority service if it can demonstrate to the state agency on aging "that services being furnished for such category [of services] in the area are sufficient to meet the need for such services in such area."

In order to assure adequate representation for needy elderly throughout the country, we believe this waiver provision should be strengthened. The Act should require that an area agency's request for a waiver be based on a public hearing. All interested parties should be notified of the hearing and given an opportunity to testify. The Act should also require that a record of this public hearing accompany an area agency on aging's request for a waiver from the state.

Finally, in order to further assure that area agencies meet their obligation to provide legal services, and to prevent misuse of the waiver, the Act should include a citizens suit provision to give needy older persons without access to legal representation because of area agency action an opportunity to commence a civil action in their own behalf.

Confidentiality. Some area agencies on aging have sought to require legal service providers with whom they contract to divulge the name and address of clients served with Title IIIB Older Americans Act funds, in order to evaluate the program. This has resulted in tension between the attempt of the area agency to monitor program effectiveness and the need of providers to maintain client confidentiality. Thus, some legal services providers are reluctant to contract with area agencies.

Revealing the identity of clients is clearly a violation of the rule of lawyer-client confidentiality mandated by the legal profession's code of professional conduct. The ABA Model Rules of Professional Conduct state at Rule 1.6 that "A lawyer shall not reveal information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation." All state bar codes are similar or identical. Moreover, the ABA has determined that the name, address and telephone number of a client receiving free legal services falls within this rule of confidentiality (See ABA Informal Opinion 1287). This encourages clients to seek legal assistance and to trust their attorneys. Many older clients, particularly, might feel embarrassed if others knew they had sought free legal advice and counsel, and this might keep them from resolving their problems.

Thus, the ABA recommends that legal services providers under the Act should not be required to divulge information to area agencies on aging which reveals the identity of clients served with Title III funds. This would not prohibit area agencies from collecting any information necessary for evaluation, planning or needs assessment. This information can easily be obtained without revealing the names and addresses of clients served.

Conclusion. Legal services enable needy older Americans to secure fundamental rights to which they are entitled. Legal services open doors for the needy elderly to other services. Legal services enhance the independence and dignity of needy older individuals. The American Bar Association maintains that the most effective approach for providing adequate legal representation and advice for needy older persons is through the combined efforts of the Legal Services Corporation, an effective Older Americans Act program, and the private bar.

We urge prompt reauthorization of the Older Americans Act, a continued priority on the delivery of legal services, a strengthening of the waiver provision of Sec. 306(b), and changes in the confidentiality requirements as discussed above.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
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TESTIMONY

ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT

PREPARED FOR

THE SUBCOMMITTEE ON AGING

OF

THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

BY

THE NATIONAL COMMITTEE ON AGING

OF

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

March 5, 1984

TESTIMONY ON RE-AUTHORIZATION OF OLDER AMERICANS ACT

The National Committee on Aging of the National Association of Social Workers (NASW) is pleased to have the opportunity to submit testimony on the occasion of the February 24, 1984, hearings on Title III of the Older Americans Act. Senator Grassley is to be commended for convening this and other hearings on the reauthorization of this important legislation.

THE INVOLVEMENT OF SOCIAL WORK WITH THE ELDERLY

NASW represents more than 90,000 professional social workers, and a sizable number of them are involved with services to and on behalf of the elderly. Our members work for State Units on Aging and Area Agencies on Aging and are represented heavily on the staffs of service programs supported by contracts under Title III. In general, the majority of our members are daily confronted with the implications of an aging society as they perform their work in hospitals, mental health organizations, family service agencies, long-term care facilities, and a wide array of other social service or health agencies. We observe first hand the stresses on family units (often with two generations over age 60) as they struggle to meet the increasing dependency needs of their older members. We also observe the difficulties that frail and isolated older persons experience in organizing services for themselves. Those of us working in hospitals all too often arrange accommodations in nursing homes for people who might have remained in the community had a suitable array of flexible services been available.

THE IMPORTANCE OF THE OLDER AMERICANS ACT

The Older Americans Act has a vital role in designing and coordinating social services on behalf of the elderly, and therefore we urge the reauthorization of the Act. The State Units on Aging and the Area Agencies on Aging (AAA) at the community level provide visible focal points for development of a coherent set of programs to address the needs of old persons. Demographic projections combined with changing family patterns (such as increased mobility, trends in divorce and remarriage, women in the labor force) suggest that, in the next decades, an enlarged group of elderly and vulnerable people will especially need this attention and that families will be more stressed than ever.

The feedback we receive from our members about Older Americans Act programs in the local communities is generally positive. Over the years, the AAA has been the single greatest force encouraging existing social service agencies in local communities to develop innovative approaches to seniors. Indeed, in some localities the AAA has been the only entity capable of stimulating such positive developments with start-up money and/or ongoing support. The ability of AAAs to act flexibly and responsibly on behalf of the elderly is invaluable.

THE IMPORTANCE OF TARGETING

In the recent past, AAAs in many communities and sometimes statewide have played important roles in stimulating the orderly development of long-term care and supportive services for the functionally impaired elderly. We urge that all AAAs be given a clear mandate to target their efforts toward those with functional needs.

Community social services for the frail elderly are so vitally needed in this country to redress the balance, which is now tipped toward nursing-home care. In-home services, home-delivered meals, and transportation programs are particularly important to this focus, although other programs play crucial roles. Note that, when functional disability is the major targeting criterion, the majority of those targeted for service will be in their late 70s and 80s, female, and poor.

THE NEED FOR MENTAL HEALTH SERVICES

We reiterate our support for the January 31 testimony of Arthur Fleming on behalf of the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging. At that time, he urged support of mental health services for the elderly. The elderly are underserved by the mental health establishment, despite a high incidence of *treatable* conditions such as depression. Mental health services are also needed for diagnosis and management of senile dementia. Some of our members working in mental health settings note that elderly persons responsible for the care of someone (usually a spouse) with senile dementia have a high need for mental health services themselves and seem responsive to brief problem-focused treatment.

THE NEED FOR CASE MANAGEMENT IN CONJUNCTION WITH SOCIAL SERVICES

Case management is increasingly coming to be a feature of AAA-sponsored programs. NASW believes that case management is a crucial aspect of an organized, responsive, and efficient system of services targeted at the frail elderly. Case management implies that some person or group takes responsibility for assessing the needs of individuals and families and arranges service plans in the light of individual functional needs, resources, and personal preference. It is a logical and important extension of the information and referral services, which are traditionally the responsibility of AAAs. In communities and states where services to the elderly are mediated by case management, this process has been a catalyst for integrating social services provided under the Social Services Block Grant with those provided by Title III of the OAA into a coherent array. We urge this coordination of services provided under OAA and Title XX as well as other community-based services in order to provide the needed continuum for effective long-term care. We believe that AAAs can play an essential role in such coordination.

Ultimately we hope that a sizable proportion of funds now used in the Medicaid program will also become available for a system of flexible community based supportive services for the frail elderly. Case management to allocate resources and monitor care plans would be a crucial component in such a system. To arrive at that goal, local planning will be needed. Agreement must be reached on the roles of agencies and organizations, the scope of services, and the way to ensure continued family support and voluntary effort, now the backbone of care for older people. We are encouraged that some states are moving in this direction (using Medicaid Waiver authorities) and that AAAs are playing major roles in these developments. We urge that this reauthorization of the OAA give State Units and AAAs the mandate to exercise leadership in development of local case-management systems and to explore ways of integrating funding streams for community-long-term care services.

SOCIAL WORK AND CASE MANAGEMENT

Social workers historically have been in the forefront of case management. Recently the profession has given new emphasis to this process. Schools of social work are beginning to prepare their graduates specifically to do case management. A Task Force of the NASW National Aging Committee is currently developing standards and guidelines for social work case management in long-term care programs. Unfortunately these standards will not be published until later this spring. However, we would like to share some basic concepts, which the Task Force is employing in its deliberations.

- o Case management and case plans must be predicted on a comprehensive assessment of functional needs, social resources (including economic resources, family support, and environmental conditions) and individual's preferences. This assessment must go beyond a narrow focus on medical concerns and address the full range of the client's needs.
- o The client, and when appropriate, relevant family members, must be integrally involved in the decisionmaking process.
- o Service plans must be designed to fit the gaps in what families and the older people themselves can provide rather than be keyed to rigid program benefits. Often, "for want of a nail, the battle is lost." The absence of small, relatively inexpensive but necessary services can force clients into more elaborate packages, even including institutionalization.

- Case management includes advocacy to assure that existing services are both accessible and delivered. The process ensures that gaps in existing services will be identified and the quality of care will be monitored.
- Assessment to determine whether an individual requires institutionally based care should occur in a home environment, whenever possible, rather than in the artificial and stressful environment of hospitals.
- Case managers should be trained and skilled in involving the client, family and significant others in the care planning process; carrying out assessments of the patient's (and family's) needs based on economical, environmental, physical, psychological and social considerations; and arranging appropriate services, based on knowledge of and interaction with the informal support system (e.g., family, friends, neighbors, churches) and formal social welfare services.
- In preparation for more widespread use of case management, the NASW Task Force is considering how to reconcile protection of clients' autonomy and confidentiality (two underlying social work values) with the development of case management systems that have real authority and effective case management information capability.

Social workers trained at both the bachelors level (BSW) and masters level (MSW) are major sources of personnel to deliver case management, with the latter also playing roles in program design, administration, and staff training. We believe that the larger social service community (which employs so many NASW members) will be receptive to AAAs redirecting their efforts toward the functionally impaired elderly and will welcome a well-planned case management approach. No single system will prove appropriate for all parts of this large and diverse country, but some system is desirable everywhere. We urge collaborative planning at state and local levels to eliminate gaps, avoid redundancy, and develop clear patterns of communication. Where friction has arisen among service providers and case managers under AAA or other sponsorship, these problems seemed to stem from lack of joint planning and discussion. Certainly at the community level, provider groups should be involved in designing the case management system.

THE NEED FOR ADEQUATE FUNDING

At the same time as we urge that AAAs target their resources to the frail elderly, we also advocate adequate funding for AAA programs, which should be at least commensurate with past appropriations. It is estimated that only a small proportion of those eligible for services under the Older Americans Act are in fact receiving them. We as a society must recognize that the increased older population will only exacerbate this current unmet need. Rationally and responsibly, we must allocate the appropriate resources to meet the need. However, just as it is unrealistic to develop a program without sufficient resources, it is also unrealistic to expect new directions without AAAs making the internal shifts in priorities consistent with targeting on the vulnerable.

We would also like to make note of the recommendations of the Federal Council on Aging that a disclosure component combined with local reviews be included as part of the Intrastate Funding Formula requirement. We feel that this refinement of the current provision would increase public participation in the Older American Act at the local level and would be a vehicle by which services provided under the act would be more widely known and used.

SUMMARY

In summary, we endorse the importance of the aging network in the development of services for the elderly and recommend reauthorization of the Older Americans Act with adequate funding levels. We especially endorse targeting of efforts toward the frail and functionally impaired portion of the senior population, most of whom will be in their late 70s and 80s and beyond. Finally, we favor the encouragement of case management, which, we believe is an important component to the delivery of services under Title III. It is, in fact, the key to gaining access to services and to their delivery in an orderly and rational manner. Therefore, we urge expansion and strengthening of case management functions sponsored under the Older Americans Act.

Thank you for considering these comments.

Written Testimony of
Eugene S. Callender
Director, New York State Office for the Aging
submitted for inclusion in the hearing record of the
Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources
February 24, 1984, Hearing on Title III of the Older Americans Act

I am delighted to have the opportunity to submit recommendations for the reauthorization of Title III of the Older Americans Act. Since its enactment in 1965, the Older Americans Act has created a network of State and local agencies working to plan and coordinate services for the elderly nationwide. By holding an initial hearing on the role of this aging network in helping reform the long term care system, this Subcommittee has clearly expressed its desire to use this reauthorization as an opportunity to further strengthen the Act.

Because the Senate version of the reauthorization has not yet been introduced, I will frame these recommendations with reference to H.R. 4785, the companion House bill. H.R. 4785 presents an excellent set of provisions for consideration by this Subcommittee as well as your House counterpart.

Targeting

Before turning to provisions reflected in H.R. 4785, however, I would like to address one area which I believe could be further strengthened, that is: the network's ability to target its services to minority and low-income elderly who are now underserved.

I am pleased that the aging network, rather than responding defensively to criticism from the Civil Rights Commission and other groups, is actively searching for ways to improve our targeting on minorities and the poor. I urge the Congress to assist us in these efforts by sharpening the Older Americans Act's focus on those elderly in the greatest economic or social need.

This summer, I convened a Task Force on Minority Participation in Aging Services to identify barriers which restrict service delivery to minorities, and to develop strategies to eliminate or minimize these barriers. Members included staff from the New York State Office for the Aging and the New York City Department for the Aging, from Fordham University, and from PROGRESS, Inc., the Puerto Rican Organization for Growth, Research, Education, and Self-Sufficiency. I am now expanding this group into a statewide task force to involve all parts of New York State's aging network to increase minority participation in employment, contracting, and service delivery.

Beginning with Federal Fiscal Year 1983, we also implemented an Intrastate Funding Formula to distribute Older Americans Act funds within New York State. This formula determines an Adjusted Population Allocation for each Planning and Service Area based on the number of people over 60, those below the poverty level, those over 75, and older minorities. The formula, which also takes into account minimum and prior-year allocations, is an effective means of targeting funds to those areas with the greatest need.

Finally, in developing my agency's management plan I established broadly defined Affirmative Action--covering service delivery and contracting as well as employment--as one of the five priorities to which our efforts are to be devoted. This agency-wide focus is reflected in the way our staff reviews Area Plans, provides training and technical assistance, and advocates on State and Federal issues.

I urge this Subcommittee to support and provide similar provisions in the Older Americans Act. For example, the way in which funds are distributed has a direct and dramatic effect on which older people are served. Funds should be distributed in ways which more closely reflect the level of need. Factors to be considered should include the distribution of minority elderly and of those over age 75 or even 85. Recent studies have shown that many "well elderly" who migrate to the Sunbelt in their early sixties later return to the Snowbelt region when they enter the "old old" years, in order to be close to their informal support network of children and families. Thus in their early sixties, they are counted towards Sunbelt allotments while in need of relatively few services; when their service needs intensify, they return north to States that have experienced declining Older Americans Act allotments because their older populations, while increasing, have been growing less rapidly than the older populations of Sunbelt States. (I would caution, however, against use of straight poverty populations in distributing funds, which would penalize those States which supplement SSI benefits and thus bring their most needy elderly above the unreasonably low poverty level.)

Since major changes in the interstate funding formula are unlikely to be enacted swiftly, I urge as an initial step towards distributing money where the need is greatest that Congress enact a hold-harmless for each State allotment. It is frustrating and unworkable to continue to try to serve increasing numbers of elderly, especially the "old old", while receiving lower allocations to the State each year despite congressional intent to maintain funding levels from year to year.

At the State level, the Older Americans Act could also mandate that intrastate funding formulas include factors reflecting the distribution of minority elderly, low-income elderly, and those over 75. These factors are extremely effective measures of need for services.

Although the current Federal regulations require that each Area Plan must specify proposed methods for giving preference to those with greatest economic or social need, they do not require any estimates of how many low income or minority elderly will be served. Any worthwhile Plan should contain this information, to permit rational judgments on whether the Area Agency will fulfill the goal of serving those most in need.

Finally, I urge that the reauthorization carve out a specific funding source for Statewide efforts to enhance the participation of low-income and minority elderly. One possibility would be a separate and additional authorization for State programs modeled after the "Senior Opportunities and Services" or SOS program which was made a permissible III-B service in the 1981 reauthorization. I had proposed, in New York State, a statewide expansion of the SOS program to improve services to the elderly poor, but lack of funding has thus far prevented that initiative from taking place.

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If this Subcommittee addresses these vital targeting issues to assure that services reach those most in need, the 1984 reauthorization of the Older Americans Act will be seen as a shining light for minority and low-income elderly at a time when most human service and civil rights issues are experiencing the darkness of Administration neglect.

Aging Network Structure

Another issue to be addressed in this reauthorization is the strength of the aging network on the State and local levels. As noted in my written testimony submitted for your long term care hearing, the network's ability to influence and coordinate programs affecting the elderly is dependent upon its clout at the State and local levels. Currently, the Older Americans Act requires that States designate a "sole State agency" to serve as the State unit on aging under section 305(a)(1); States also designate Area Agencies on Aging under section 305(a)(2)(A). Yet, by statute, these State units and Area Agencies on Aging could be multipurpose agencies with little or no focus on elderly people. In light of the Administration on Aging's proposed regulations, which would delete the current regulatory provisisions requiring single-purpose agencies or single-purpose units within larger organizations, I recommend that the aging network be strengthened by requiring that State units and Area Agencies be single-purpose agencies which, where applicable, constitute primary bodies (equivalent to departments) of State or local government. The regulatory provision requiring a full-time director and adequate number of full- and part-time staff should also be written into law. Only with this primary status will the network's views on policies affecting the elderly be fully heard.

Regulations

The Older Americans Act regulations proposed by the Administration on Aging last year prompt some concern over the requirement proposed by H.R. 4785 for new regulations to be issued within 180 days of enactment of this reauthorization [§ 206(c)]. Last year's proposals, for example, did not even address the major changes in the Act made by the 1981 reauthorization; instead, they would have eliminated many of the existing provisions for a strong network with effective public participation. Although I agree that the right kind of Federal regulations would help enhance the operation of Older Americans Act programs, I would rather have no regulations than the type we saw proposed last year.

I would also urge that this reauthorization address a serious flaw in the existing regulations' provision on confidentiality. Unlike the Federal Privacy Act and virtually every other Federal or State regulation or statute, the current regulations provide no means for dealing with emergencies. Under § 1321.19(a)(1), "no information about an older person [may be] disclosed by the provider or agency in a form which identifies the person without the informed consent of the person or of his or her legal representative" except for program monitoring. Taken literally, this provision would prohibit a home-delivered meals provider who finds an older person passed out on the floor from calling an ambulance unless the older person had previously consented to such action. I have no hesitation in acknowledging that I would violate this regulation if such a situation arose--but this ludicrous requirement has imposed significant difficulties in our efforts to coordinate procedures with social services programs operating under the more reasonable standards of the Federal Privacy Act and similar State requirements.

I also urge that the regulatory definitions of "greatest economic need" and "rural areas" be overturned in this reauthorization. When the "greatest economic need" language of the Older Americans Act was translated into a regulatory standard in 1980, the Administration on Aging rejected the majority of public comments and settled upon the poverty level as the sole standard for economic need. But in States like New York which supplement the Federal SSI payment, even SSI recipients' incomes exceed this unreasonably low level. Targeting on low income elderly should recognize that SSI recipients, for example, are in fact in "greatest economic need" even if their incomes have edged above the poverty line. The definition of "rural" in the current regulations--any county outside a Standard Metropolitan Statistical Area--is also unreasonable. Some of New York State's most rural counties are excluded from this definition. Even worse, we have an ever-declining number of counties that meet this definition; yet the Older Americans Act requirement of spending each year in rural areas 105% of the amount spent in rural areas in 1978 means that we are required to spend more money in fewer counties. Each time another county is classified as within an SMSA--simply because a few suburbs near the county line have grown--we have to spend more and more in fewer and fewer counties. Both "rural" and "greatest economic need" should be left to State definition.

Service Population

H.R. 4785 would, for the first time, specify that the "older people" to be served under Title III-B are those over 60 [§ 303(2)]. As a general rule, I have no objection to this definition, which is also used for New York State's Community Services for the Elderly program. However, I do urge that some coordination be permitted between the supportive services program under Title III-B (serving "older people", which will now mean those over 60) and the nutrition services program under Title III-C (serving those over 60 and their spouses). Under current law, younger husbands or wives can share meals (funded under III-C) with their older spouses once they make it to the senior center, but they cannot ride the bus (funded under III-B) that gets them to the center to start with. Participants in the Title V program, who may be only 55, should also be eligible for related supportive services such as transportation.

I also urge that some consideration be given to services which, though provided to those under 60, are designed to increase understanding and concern for older people. Examples would include preretirement education and the health and life insurance counseling which would be included as permissible III-B services under this bill [§ 311(a)(2)]. Because of the critical role that families and other parts of the informal support system play in providing care for the elderly, I would suggest that the network's ability to assist younger people (through training, counseling, etc., and perhaps ombudsman services) be protected, while "hard" services are limited to those over 60.

Fiscal Issues

The flexibility provided in 1981 to transfer up to 20% of funds between Titles III-B and III-C has worked well, and I support the proposal in H.R. 4785 to increase this level to 25% [§ 307(b)(5)]. I also applaud the House bill's intent to continue to increase per-meal reimbursement rates under the U.S. Department of Agriculture's commodity/cash-in-lieu program [§ 309(a)(2)] rather than shifting this program, as proposed by the

Administration, to a formula basis which would eliminate the incentive to maximize the number of meals served. Because of the continuing difficulties in obtaining adequate appropriations, I also support the limitation of Federal evaluation funds to 1/4 of 1% (rather than the current 1%) of appropriations [§ 207(b)].

The most pressing fiscal issue, in terms of the aging network's ability to meet its responsibility of developing coordinated service systems, relates to State administrative allotments. Local coordination with health, social services, and other delivery networks is impossible unless their parent State agencies coordinate their requirements. State Units on Aging, trying to represent the interests of the elderly amidst the policy and budgetary ferment of State government, have actually been awarded decreasing funds to administer growing Older Americans Act programs and to promote systematic reforms at the State level.

Over each of the past three fiscal years, funds appropriated for State activities under the Older Americans Act have been less than for Federal Fiscal Year 1981. Because the distribution formula for these funds includes substantial minimum base and hold harmless factors, large States like New York have suffered disproportionately. Despite the growth in our responsibilities, our service programs, and our elderly population, New York's basic allocation for State activities is now some $200,000 less than in fiscal 1979.

Thus, our ability to contique these efforts without harming the quality of service delivery of Older Americans Act services is in serious jeopardy.

Although the Reagan Administration's block grants authorize administrative expenditures up to 10% or 15%, I urge a shift in the Older Americans Act to authorize State units to spend no more than 5% of their Title III allotments (or the fiscal 1981 level, whichever is greatest) for State activities including administration and systems development. This shift will recognize the expansion of service programs in recent years and permit State units to expand their efforts in promoting and facilitating system reform.

Ombudsman Program

The long term care ombudsman program is an excellent service provided to the institutionalized elderly, and I urge the expansion of this program with the participation of each Area Agency on Aging. In light of the diminished focus on public participation in last year's proposed OAA regulations, I recognize the importance of language directing State Units to consider the views of Area Agencies, older people, and provider agencies in operating this program [§ 306(a)(3)(D) of H.R. 4785].

In New York State, we do consult regularly with all these groups, and I believe our program is a strong one because of this consultation. However, great care should be taken to emphasize that the role of the ombudsman is as a patient's advocate, not a spokesperson for facilities or any other group. We should not dilute the focus of this program by requiring the ombudsman program to process complaints by providers (except those on behalf of residents) or by otherwise limiting the responsibility of ombudsmen to represent patients and residents.

Competitive Process for Nutrition Contracts

The "competitive process" requirement enacted in the 1981 reauthorization generated considerable confusion in the aging network. As you know, the Administration on Aging has indicated that this requirement applies only to procurement contracts for nutrition, not to awards of financial assistance to nutrition providers. (Even with awards of financial assistance, however, a fair process permitting all applicants the opportunity to be considered--as through a Request For Proposal mechanism--should be used.) Because various State laws (including New York's) set forth detailed provisions pertaining to strict competitive bidding procedures which require selection of the lowest responsible bidder, I would suggest that the term "applicant" be substituted for "bidder" throughout section 501(b) of the Comprehensive Older Americans Act Amendments of 1978. With this modification, the inclusion of an evaluation of applicants' experience in providing services to older individuals (as proposed in H.R. 4785) would be a worthwhile addition.

As noted in my long term care testimony, the ability of State and Area Agencies on Aging to coordinate and improve services to older people is dependent on their remaining free to advocate on every level where system decisions are made--Federal, State, and local. Yet recent efforts by the Office of Management and Budget to stifle political advocacy by federally funded entities contain only a minor exception for activities mandated by law.

Most Area Agencies probably believe they are required to advocate on Federal and State issues as well as local ones. Certainly they could not fulfill their responsibility to develop comprehensive and coordinated systems if they ignored higher levels of government. One cannot realistically speak about long term care reform without examining the need for changes in Medicare, Medicaid, the Social Services Block Grant, and HUD congregate housing programs, as well as the Older Americans Act. Yet the provision of the Older Americans Act mandating Area Agency advocacy, section 306(a)(6)(D), requires only that they:

> (D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect the elderly;

Similarly, the mandate for State advocacy in section 305(a)(1)(D) requires State units on aging to:

> (D) serve as an effective and visible advocate for the elderly by reviewing and commenting upon all State plans, budgets, and policies which affect the elderly . . .

To assure that State and Area Agencies remain able to represent problems of the the elderly across all levels of government, I strongly urge that their responsibilities for advocacy at Federal, State, and local efforts be specifically referenced in these sections of the Older Americans Act.

The House version of the reauthorization bill (H.R. 4785) is an excellent one, and I look forward to its Senate counterpart. The proposals I have made in this testimony are designed to further strengthen the bill and the aging network. But the true strength of the network is in the concern and dedication of millions of elderly people and their advocates, including each Member of this Subcommittee, who continue to demonstrate the success that we can achieve by working together. I appreciate the opportunity to present these views, and I look forward to continued consultation and cooperation in the months and years ahead.

Senator GRASSLEY. Our hearing is closed now. In closing I would like to say thank you for all those who testified, for their attention, for their patience, and all of you who are in the audience and did not participate I want to make one last offer, that for 15 days the record will remain open if any of you have testimony you want to submit. Keep it to a minimum amount of pages. We would appreciate any additional comments.

Meeting adjourned.

[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

Title IV—Training, Research, and Discretionary Projects and Programs

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TUESDAY, FEBRUARY 28, 1984

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:38 a.m., in room SD-628, Dirksen Senate Office Building, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

Present: Senators Grassley, Pell, Thurmond, and Metzenbaum.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator **GRASSLEY**. I am Charles Grassley, chairman of the Subcommittee on Aging of the full Committee on Labor and Human Resources, and I want to welcome everybody to this hearing. This is the fourth in a series of hearings that we have had on the Older Americans Act; this one will be on title IV.

We have one more hearing to go and then we hope to get early markup of this bill in subcommittee and full committee so that it can be considered on the floor of the Senate by the time that Older Americans Month arrives in May.

I hope I speak for members of the subcommittee when I say that I want to get this act through by April as well. If our colleagues in the House also finish by April, as they have indicated to me, then, of course, we can get this bill to the President early in May for his signature.

Most of the aging organizations which are headquartered here in Washington have indicated support for this schedule. In my case, I am going to do my best to see that we accomplish that.

Our hearing today takes up title IV, as I indicated. Title IV is that part of the act over which the Commissioner on Aging has considerable discretion. The Commissioner has used title IV funds to support the long-term care channeling demonstrations, the long-term care gerontological centers and several national aging policy centers, legal services and ombudsman activities as well as education and training, and other research and demonstration activities.

I am not going to go into any further description of the title. I am going to incorporate the rest of my opening statement in the record to preserve time for everybody to participate.

I think that we will hear more from her today about the program's accomplishments, so I will not say any more about them and will turn to some of the main issues in which we are interested.

Two years ago, the Office of Human Development Services changed the way grants are awarded in the four program offices which it oversees, including the title IV program. Our hearing will take testimony today on how the resulting coordinated discretionary program has been working.

We are interested in two broad areas: First, the process by which the funds available under title IV are awarded and administered. And second, the substantive emphasis of the program.

With respect to the first area—the way the program is administered—we are interested in a number of issues: First, we need to know whether an adequate planning process is followed. Some people who follow the program have asserted that it does not have sufficient focus and direction. The Federal Council on Aging and other groups have suggested that a statement of purpose be incorporated into title IV as a way of providing some legislative direction for the activities funded under it.

Second, we need to know more about how grant awards are made. Specifically, we need to know whether the most qualified applicants, as determined by the peer review panels, have been chosen to participate in the program, and, if they have not been, whether deviations from panel recommendations have been justified.

Third, we need to know whether the projects supported by the program are adequately monitored. An analysis by the Health and Human Services Inspector General's office released in September, 1983, found that the coordinated discretionary program had not appropriately monitored its grant projects. The Office of Human Development Services agreed to take corrective action, and it would be helpful to know whether the deficiencies have been corrected. Adequate monitoring and technical assistance are important, both to insure that public funds are properly spent and to help grantees who might need help to complete a project in a timely and competent fashion.

Finally, some observers of the program have asked whether, once research and demonstration projects are completed, their reports are disseminated widely enough, or whether their results are appropriately utilized. In fairness, I should point out that this question does not originate with the Reagan administration, but was heard under preceeding administrations as well.

With respect to the second area—the substantive thrust of the program—we are also interested in a number of issues: first we need to know how some of the current activities of title IV have been working and whether the administration recommends that they continue. I am particularly interested in learning whether title IV activities contribute to better service delivery. This is particularly important in view of the recommendation in the administration's budget submission for fiscal year 1985; namely, that the program's funds be cut to $5 million.

Second, we need to know more about some of the newer program directions set by Commissioner Tolliver. I am particularly interested in the private sector initiatives which are designed, as I understand it, to generate continuing private sector involvement in providing services of various kinds for older people. It seems to me that this approach can help us to get a lot of leverage for our very limited Federal dollars. We will hear from a representative of one of these projects today--the OASIS project of St. Louis, MO. We will also hear about an elder abuse project in Rhode Island and a rural black college training program underway in Hampton, VA.

Finally, we need to know whether it is advisable to include in the Older Americans Act Programs activities which can help Alzheimers patients and their families. A bill, H.R. 4274, has been introduced in the House to amend the Older Americans Act to include Alzheimer-related activities by Representative Olympia Snowe, from whom we shall hear today. A companion bill, S. 2221, has been introduced in the Senate by a member of this subcommittee, Senator Metzenbaum. I am very pleased to say that, in addition to Representative Snowe, we will hear today from Senator D'Amato of New York, who feels strongly that more should be done to help those who suffer from Alzheimer's disease.

I have an opportunity to welcome a friend and former colleague of mine, Congresswoman Olympia Snowe, from the State of Maine, and also a friend who was elected to the Senate at the same time I was, Senator D'Amato of New York.

I would ask you to proceed, Senator D'Amato, and then Congresswoman Snowe. I want to thank you both very much for your interest in this area.

STATEMENT OF HON. ALFONSE D'AMATO, A U.S. SENATOR FROM THE STATE OF NEW YORK; AND HON. OLYMPIA J. SNOWE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Senator D'AMATO. Thank you very much, Mr. Chairman, I am indeed privileged and pleased to be asked to testify today at these hearings. I have been a strong supporter of the programs of the Older Americans Act. I have been especially impressed by the support for this act with the private sector groups and its popularity with the elderly.

My constituency, old and young, is also concerned with another problem facing the elderly today--Alzheimer's disease. Speaking with many senior citizens from my State, this tragic disease does more than concern them; it frightens them, it terrifies them.

There is nothing more terrifying than the possibility of losing one's mental capacity. Most tragically, it is a slow, debilitating and degenerative downhill course for Alzheimer's disease victims, and science thus far has found no way to arrest this decline.

Fortunately, the Government is beginning to become more interested in research and funding of research for this disease. I would like to commend at this point the chairman of this committee and my colleague from Maine, Congresswoman Snowe, for their exhaustive work on this issue. Because of your efforts and those of us in the Congress who have championed this cause, the Federal Government is now becoming more actively involved.

Research into the cause and cure of Alzheimer's disease, however, is only half the problem. Many doctors concede there is little that now can be done to help those who have already contracted the disease. This committee is correct to consider the inclusion of custodial care and respite services to assist the Alzheimer's disease sufferer and, particularly, their families.

Alzheimer's disease costs this Nation over $25 billion annually. Up to a million people are believed to be affected, five percent of those over 65 years of age. Because of the degenerative nature of the disease, it is believed that over a quarter of all nursing home patients in America have Alzheimer's disease. But who takes care of the Alzheimer's disease sufferer when they are not in the nursing home? The family. Unfortunately, there is now little assistance available to the afflicted family.

Proposals that this committee is considering would finally address this problem. Whether respite services come under title IV or under title III of the Older Americans Act is up to this committee to decide. The overwhelming need is obvious. This is dramatized by the growth of the Alzheimer's Disease and Related Disorders Association, which has hundreds of chapters throughout this Nation. To add custodial and respite services is a very timely act.

In September 1983, I participated in a Senate Aging Committee hearing on Alzheimer's disease in New York. Many of the witnesses told tragic stories of loved ones who slowly were mentally drifting away from them. They spoke of the tremendous personal commitment they had to make as the victims became less able to take care of themselves. Alzheimer's disease affects the family emotionally, physically, and financially.

I want you to know that you may count on my support to reauthorize the Older Americans Act. You should also know that as a member of the Appropriations Committee, I will see to it, Mr. Chairman, that not only is the act authorized but fully appropriated and funded.

Again, Mr. Chairman, thank you for giving me the opportunity of sharing these thoughts with you and the committee.

Senator GRASSLEY. I appreciate your testimony very much, and particularly your offer of help as a member of the Appropriations Committee because that authorization act is of little value if we do not get the appropriated funds to see that it is carried out.

And I do not know about you, Senator D'Amato, but in the short period of time I have been in the Senate, I think probably public attention to Alzheimer's disease has grown more rapidly than almost any other disease I can remember in my lifetime.

Senator D'AMATO. It certainly has, Mr. Chairman, and I think it is interesting to note that young people have become very conscious of this disease; they see it, whether it is with their grandparents or with their parents. I think we have to build up the momentum to see to it that there is proper funding for research, custodial care, and care at home. People do not want to see their loved ones committed to institutions, and yet it becomes a tragic, very difficult burden for them to deal with their loved ones who are afflicted with Alzheiners disease at home.

Again, I would like to commend Congresswoman Snowe for her strong support and sensitivity, and you, Mr. Chairman, for being a leader in this area.

Senator GRASSLEY. Yes. I want to invite you, Congresswoman Snowe, whatever your testimony might be, to tell us about that fine piece of legislation you have introduced, H.R. 4272, on this subject.

Ms. SNOWE. Thank you, Mr. Chairman, and it certainly is a pleasure to be here today to be able to discuss some of the legislative priorities for title IV under the Older Americans Act reauthorization bill.

As you know, a major reauthorization bill, H.R. 4785, has been introduced in the House by Chairman Andrews of the Education and Labor Subcommittee on Human Services. I am an original cosponsor of that bill because of my belief that these programs do indeed benefit our Nation's elderly population.

I am also pleased that this bill incorporates several provisions relating to Alzheimer's disease. Last summer, I conducted a field hearing in the State of Maine on Alzheimer's disease to explore the illness' effect on victims and their families, as well as to also explore the possible gaps in services to victims and their families.

Witness after witness cited examples of the lack of trained personnel, whether it was in the nursing homes or community health agencies or hospitals, and even veterans' hospitals.

So in response to that testimony, I introduced legislation last November to amend title IV of the Older Americans Act, which essentially would give authority to the Administration on Aging to assign student grant priority to those university or vocational students who indicate that they would specialize in custodial or skilled care for Alzheimer patients or any other individual who has a related disease or disorder.

In addition to that, the legislation would require that the State area agencies establish community training and demonstration projects relating to the needs in the care of Alzheimer patients.

I think it is important that we provide assistance to the families who take care of Alzheimer victims. It is necessary that these families have educational as well as direct assistance, and I think that this assistance should be coordinated by the State area agencies.

I think that, as Senator D'Amato indicated, we can do no less for those individuals who suffer from this terrible disease. We know that up to 4 million people in this country are afflicted with this disease; that 1 in 6 Americans will be afflicted by this disorder unless a cure is found; and that more than one-half of the nursing home patients are Alzheimer's victims.

Beyond that, it is the fourth leading cause of death in this country, so I think we have to do everything we can to minimize the pain and the burden that it brings to the victims and their families.

Mr. Chairman, I know that your subcommittee has had a number of hearings on Alzheimer's disease, and I will not elaborate on the ramifications and the dire consequences of this dreadful disease.

Suffice it to say that we are all aware of the long-term debilitating nature of this disease and the terrible toll it takes on the victim as well as the family. We know, Mr. Chairman, that there is a dirth of professionals who are properly trained in this area to take care of Alzheimer's patients. Therefore, we think this would be a step in the right direction in filling that void.

The Older Americans Act has been a success story in and of itself, and I think that if we could incorporate those Alzheimer-related provisions, then we will be adding a new dimension and responsiveness to our elderly population in this country.

Finally, Mr. Chairman, I want to congratulate you for your leadership in this area, and for the efforts you have undertaken on behalf of your subcommittee to explore what I think is one of the most tragic diseases. As somebody described, it is a disease where a funeral never ends.

So we have to do everything we can, I think, in the Congress to alleviate the pain and the hardship that Alzheimer's disease does bring to those who suffer from this terrible disease.

Thank you.

Senator GRASSLEY. Thank you very much. Do you anticipate, Ms. Snowe, that your legislation will be incorporated on the House side at the subcommittee level?

Ms. SNOWE. Yes, I do. There is a lot of support for it and it has already been incorporated in the original bill that has been introduced in the House, so I do not envision that there will be any problems in getting it all the way through.

Senator GRASSLEY. And pretty much as you had originally written it?

Ms. SNOWE. That is correct; identical.

Senator GRASSLEY. I do not have any questions for either one of you, but I want to remind you that my colleagues are not here and you might expect questions in writing, and we would appreciate your responses.

I say that not only to you two Members of Congress, but to any witness today. The record normally stays open for 15 days, so we would appreciate a response in that period of time.

Let me know how I can work with both of you on this subject so we can be mutually supportive. Thank you very much.

Ms. SNOWE. Thank you.

Senator D'AMATO. Thank you, Mr. Chairman.

Senator GRASSLEY. We are now ready to go to our next witness, who is Dr. Lennie-Marie Tolliver. I almost see her so much that I feel guilty calling her Dr. Tolliver. She has traveled to 45 States since she has been Commissioner on Aging to review programs under her direction. She just testified before this subcommittee last week, and this may be the last time we will have to call you before we mark up the bill.

Before I have you start, Ms. Tolliver, I want to recognize a constitutent of mine who is on the next panel of people who are going to testify. And the reason for my recognizing her at this point is because at 10, Senator Pell is going to come and take over for at least 1 hour while I go to the Finance Committee and make determinations on whether or not we are going to have a $100 billion debt reduction package that Senator Dole is trying to put together; I am a member of that subcommittee.

I want to apologize to people who are on panels who will appear for that period of time that I will be gone, but I appreciate very much my constituent, Mary Oliver. She is president of the Alzheimer's Disease and Related Disorders Association of Des Moines. We asked her to come because we feel that she will be able to help us get some perspective on the two bills which have been introduced to amend the Older American's Act so as to include title IV Alzheimer's disease-related activities.

I see she is in the back of the room there. I want to say thank you for coming, and maybe sometime between now and noon you and I will be able to get together and have a private discussion. I am sorry I will not be here, probably, when you testify.

Would you proceed, and also introduce the people that are with you, Ms. Tolliver?

STATEMENT OF LENNIE-MARIE P. TOLLIVER, COMMISSIONER, ADMINISTRATION ON AGING, ACCOMPANIED BY MIGUEL TORRADO, OFFICE OF PROGRAM DEVELOPMENT, OFFICE OF HUMAN DEVELOPMENT SERVICES; M. GENE HANDELSMAN, DEPUTY COMMISSIONER, ADMINISTRATION ON AGING; AND CHARLES E. WELLS, ASSOCIATE COMMISSIONER, ADMINISTRATION ON AGING

Dr. TOLLIVER. Good morning, Mr. Chairman. On my right is Charles Wells, the Associate Commissioner of the Administration on Aging, whose office is responsible for the title IV program.

On my left is M. Gene Handelsman, the Deputy Commissioner, and to his left is Miguel Torrado, who has responsibility for the Office of Human Development Services process of awarding discretionary grants.

I am pleased to appear before you again today to discuss another section of the reauthorization of the Older Americans Act of 1965. Last week, I described the administration's proposals for title III of the act, and today I will focus on title IV.

I would like first to explain our legislative proposals for title IV in the 1984 reauthorization of the act, and then our program plans for this year.

As it presently reads, title IV is lengthy, too restrictive and difficult to administer. We propose to insert a new section stating the purpose of title IV as a practical guide to the administration of this title. We would also combine the education and training sections into a new similar, but shorter section.

We further propose combining the sections on research and demonstrations into a new section, thus eliminating the elaborate description of areas of innovation to which the Commissioner must give attention in making demonstration grants.

We would also eliminate the separate sections on special projects in comprehensive long-term care, special demonstrations on legal services, and utility and home heating cost demonstrations. Any special attention needed by these subjects could be given under the general demonstration project authorization or by the authorization for national impact activities, which we propose to continue without change.

We are requesting an extension of the title IV authorization for 3 years. Language is included to ensure that there is an equitable distribution of funds between projects serving urban areas and rural areas.

The budget request for title IV for fiscal year 1985 is $5 million, a $17,175,000 reduction from the current estimate for fiscal year 1984. This reduction reflects a departmentwide policy of targeting limited resources at the Federal level to programs which provide direct services, such as the title III program. It is also consistent with the Office of Human Development Services policy of maintaining support for direct-service activities by reducing lower priority, nondirect service activities.

We believe that through funding of high-quality, priority projects and more effective use of the existing knowledge and experience gained in past and current research and demonstration activities, we can continue to fulfill our mandate.

We believe that thoughtful and selective funding decisions will also enable us to continue to leverage large and equally important programs and benefits for older persons from other sources.

This decision, of course, was difficult to make. But in a time of budgetary constraints, program choices are necessary. We believe that it is imperative that needed direct services to older persons not be reduced, and that all resources available to older persons be maximized.

Currently, the major thrust of activities under title IV may be described under three categories. Service system development is support of efforts designed to facilitate the development of community-based services for older persons, with special emphasis on older persons in greater social or economic need.

Service system management consists of support of actions designed to assist State and area agencies on aging in achieving greater effectiveness and efficiency in program planning and administration.

Support activities, the third category, build a number of generic functions necessary to achieve the goals of the Older Americans Act, including a variety of in-service, short- and long-range education and training activities.

Specifically, title IV funds support grants and contracts to provide adequately trained personnel in the field of aging, to improve knowledge of the problems and needs of older persons, and to demonstrate better ways of improving the quality of life for these older persons.

The Administration on Aging participates in the Office of Human Development Services' coordinated discretionary funds program, as well as in specialized programs such as our national impact activity.

The opportunity to participate in the crosscutting program affords us an opportunity to address issues which affect older persons as well as other vulnerable groups. The process provides the Administration on Aging with an opportunity to improve coordination of activities with other Federal programs in the Office of Human Development Services, and reduces duplication which, in turn, helps to keep down the cost of the program.

We believe that this approach has given a substantial added dimension to our efforts to address the broad spectrum of actions appropriate to helping older persons maintain their independence.

It has also helped us to leverage other traditional fiscal and programmatic resources in support of these efforts. I have transmitted to the Congress a complete list of the grant awards made by the Administration on Aging in fiscal year 1983. Therefore, I will not discuss them at length today.

During today's hearing, several of our grantees will have an opportunity to discuss their particular programs with you. There are several initiatives that I wish to mention today in an effort to show the broad spectrum of our activities and our programmatic thrusts for the immediate future.

[Senator Pell assumed the chair.]

Dr. **Tolliver**. One of these relates to the Alzheimer's disease initiative that has been established within the Department of Health and Human Services as well as the Administration on Aging. Our efforts in the Alzheimer's initiative are carried out principally by the Health Policy Study Center that we support and our 11 long-term care gerontology centers, and uses our immediate network—the State and area agencies on aging.

Our thrust is to increase the number of local self-help support groups available to provide assistance to families in coping with the problems associated with the disease. We have also been pursuing since 1981 an initiative to link the generations.

Community-based long-term care remains a high priority, and I have mentioned before, the support of 11 long-term care gerontology centers that are university based. Within the past couple of months, we have reached an agreement with the National Institute of Mental Health to bring together the mental health and the aging network to improve the access of older persons to mental health services.

Volunteerism has been a very important area. We have worked to leverage more volunteers, and also to encourage the use of persons with specialized skills and knowledge in helping the network to better serve older people.

Science and technology is an area that we are moving into, and hope that during the early part of the summer we will have a major national activity that will support us in our thrust there.

As part of our effort to create a systematic body of knowledge in the field of aging, the research and demonstration program seeks to give added emphasis to coordinating and consulting with other Federal agencies which are legislatively mandated to serve the Nation's elderly.

During fiscal year 1983, in addition to the memorandum of understanding with the National Institute of Mental Health and the memorandum of understanding with the Public Health Service, we have worked with other Federal agencies, such as the Urban Mass Transportation Administration of the Department of Transportation, and jointly, during fiscal year 1984, will sponsor a national and an international conference on serving the needs of the elderly and the disabled in the area of transportation.

We have an ongoing agreement with the Department of Housing and Urban Development, and during the fall expect to cosponsor a national conference that will facilitate skill development in housing managers.

We believe that the use of special initiatives has given a substantial added dimension to our efforts to address the broad spectrum of actions appropriate to helping older persons maintain their independence, and that we have been successful in leveraging fiscal and programmatic resources from many sources in our efforts to serve more adequately the needs of older people.

This concludes my prepared statement. I appreciate the opportunity to testify on the reauthorization and programs of title IV of the Older Americans Act, and I will be happy to answer any questions which you may have.

Thank you.

[Responses of Dr. Tolliver to questions submitted by Senator Grassley follow:]

QUESTIONS FOR DR. TOLLIVER FROM SENATOR CHARLES E. GRASSLEY

PRIVATE SECTOR ACTIVITIES

QUESTION: I am intrigued, as I said in my introductory remarks, by your private sector initiatives. It seems to me that projects like these offer promise of generating greater and continuing private sector involvement in solving some of the problems an aging population presents.

Do you intend to continue this private sector initiative? And, if so, what kinds of priorities within it are you considering?

ANSWER: The Administration on Aging believes that considerable opportunity exists for expanding the level of services to older persons by enlisting the assistance of agencies and organizations in the private sector. We have already demonstrated that much can be accomplished by forging an effective partnership between public and private sector agencies.

- an award to Chautauqua Northwest (Washington) seeks to establish close linkages between the business community, the Aging Network and older people themselves to the benefit of expanding services and opportunities for older persons;
- MARTECH seeks to apply current technology to the needs of older persons by encouraging the business community to manufacture and market products of greater benefit and need to older persons;
- OASIS seeks to have retail stores expand the cultural, educational and service opportunities available to older persons in shopping malls;
- retirees of the Carbide Corporation are volunteering their talents to improve the capacity of agencies of the Network on Aging;
- National Voluntary Organizations for Independent Living for the Aging seeks to mobilize the resources of scores of national organizations to expand the level of commitment and services to older persons;

In our Gerontological Career Preparation Program a special emphasis is directed to expanding the awareness of allied professions to the needs of older persons. Training and development activities are now underway which focus attention on pharmacists, podiatrists, physician assistants, optometrists, architects and business managers.

A number of special initatives are underway in the agency which will have impact on the private sector. They include a volunteer strategy, a science and technology strategy, and a foundation initative. All of these efforts will be tied together within the framework of a private sector strategy now under development in the agency.

Because of the opportunities that exist in this area for expanding services for older persons, it is my intention to continue efforts in these areas.

TITLE IV ACTIVITIES AND IMPROVED SERVICE DELIVERY

QUESTION: How do Title IV activities contribute to better service delivery? Which Title IV activities are directly related to improving service delivery?

ANSWER: Many of the activities underway under Title IV are directly related to improving the level and quality of services for older persons. For example:

- o under the Allied Professions Training Program resources are devoted to improving services to older persons by professionals through the training of....
  - pharmacists
  - podiatrists
  - occupational therapists
  - law enforcement officers
  - physicians assistants
  - optometrists
- o under the Model Project and Demonstration Program, attention is devoted to upgrading and expanding the level of services for older Americans - including:
  - awards to Stanford Research Institute, the National Association of Counties and the U.S. Conference of Mayors have assisted local governing bodies better apply their governance authorities (taxation, zoning, ordinances) to the benefit of older citizens;
  - the American Bar Association is assisting corporate legal officers provide "pro-bono" legal services to older persons nationwide;
  - the University of Michigan is developing a national resource bank of employment plans for assisting medium-sized businesses retain their older workers;
  - the Bureau of Maine's Home Equity project is providing opportunities for families, the legal profession and the financial community to provide innovative housing opportunities for the elderly throughout the State;

- OASIS in St. Louis, Cleveland and Baltimore is providing unique services and opportunities for older persons in shopping malls;

- the Wisconsin and Michigan Mental Health Awards are opening new opportunities for older persons suffering from mental health problems;

- the Rural Congregate Housing Project in Iowa is opening new service opportunities for the rural elderly; and

- the Iowa Lakes AAA (Iowa) Management Project is developing new management systems for small Networks on Aging agencies - thus improving the level and quality of services.

o All of the Long-term Gerontology Centers are devoting energy to providing direct assistance to the agencies of the Netwok on Aging - with special emphasis on Alzheimer's Disease, mental health matters, long-term care and general health issues.

In summary, many efforts under Title IV are directly or indirectly related to improving the level and quality of services to older persons on a national scale.

Question: With respect to the monitoring shortcomings that the Inspector General found in the coordinated discretionary program, to what extent was the Title IV program criticized by the IG, and, to the extent that there were shortcomings in the Title IV program, can you tell me what steps have been taken to correct these deficiencies?

Answer:

- First, the review by the Inspector General did not cover projects awarded under the coordinated discretionary program. The specific grants cited in the report as examples of poor practice all predate FY 1982, the first year of the coordinated discretionary program.

- Three AoA projects were cited in the IG report. Of these three, one was a grant, which the report stated lacked sufficient submission of progress reports, and the other two were cooperative agreements, which the report stated were not structured correctly for that type of procurement.

- Independent of the IG audit, HDS had already assessed the need for and had undertaken major improvements in project management, by limiting the use of grants awarded outside of competition, by automating the grants operation, and by raising the standards of expectation for the financial and programmatic monitoring of grantees. AoA, along with other program offices in HDS, participated in this effort, with support to AoA project officers provided by the HDS grants management office.

- HDS has implemented an automated system under the Grants Management Information System (GMIS) which enables all HDS program offices, including AoA, to monitor the receipt of required reports (both financial and programmatic) and to take prompt action against recipients who fail to comply with reporting requirements. HDS has also implemented a grants tracking system (GRATIS) which provides program information to project officers. AoA also has access to this system.

- In regard to monitoring, it has been necessary to establish priorities for use of travel funds for on-site monitoring and to seek other methods, such as telephone communication and written materials, for evaluating grant performance. This monitoring is to be done in compliance with strengthened guidelines developed and published as internal policy guidance to HDS managers. Updated training and guidance has also been provided on making determinations among the different types of procurement -- contracts, grants, and cooperative agreements. This guidance was developed based on departmental rules and requirements governing management of procurements.

o In addition, AoA has instituted internal guidance regarding project management, since all awards made with AoA funds are managed by staff responsible to the Commissioner. New guidance has been issued within AoA which more clearly defines the role of project officers. In particular, the guidance gives greater responsibility to project managers to follow progress on grants and to ensure that results are obtained.

DIVISION OF TECHNICAL INFORMATION AND DISSEMINATION

QUESTION: I understand that a new Division of Technical Information Dissemination was created in the last reorganization of AoA. Is this correct? Is this office designed to help in the dissemination of Title IV reports?

ANSWER:

- It is correct that AoA created a new Division of Technical Information and dissemination last April. This unit is charged with responsibility for planning and overseeing the AoA dissemination strategy on an agency-wide basis.

- This Division is responsible for insuring: that information about reports is available to potential users, that the reports are included in major clearinghouses and that special efforts are taken to insure that the most important results receive additional publicity and distribution.

PRIORITIES UNDER TITLE IV

QUESTION: Are you in a position to tell us which Title IV activities would survive in a 5 million dollar program? That is, can you give us a priority ranking of the various activities funded under Title IV?

ANSWER:

- o Support for high priority projects will continue to be provided with a $5 million funding level. This support will include knowledge-building and technology transfer to assist and build the capacity of State and Area Agencies on Aging. Education and training activities will focus on training persons interested in working with older persons who are minorities and older persons living in rural areas. Demonstration, research, and model projects will continue to carry out innovative and developmental projects which address the improvement of services to low income and minority older persons in such areas as housing, employment, health and legal services. Priority will be given to those projects and activities which build upon the experience gained by State and local agencies in utilizing "State of the Art" service systems management methods.
- o At this time I cannot provide an ordered ranking of priority activities under Title IV. I have noted those areas which I see as being priorities.

TITLE IV ACTIVITIES UNDER SECTIONS 423, 424, 425, AND 426

QUESTION: The 1981 Amendments to the Act added sections 423, 424, 425 and 426. These sections called for different kinds of special projects; namely, in comprehensive and long-term care, in legal services, in national impact activities, and in utility and home heating cost demonstrations.

What is the status of the special projects funded under these sections? Does the Administration support continuation of these sections of the Act, or have they achieved their purpose and, if so, should they be discontinued?

ANSWER:

- o In the last several years the Administration on Aging has made awards in a number of the areas mentioned in your question. Information on a number of these activities has been included in the annual report which was transmitted to Congress recently. Added information about current activities is included in a summary of FY 1983 awards under Title IV which also has been provided to members of Congress.

- o The Administration proposal for Title IV, which I have described for you, would remove the particular types of activities mentioned presently under Title IV in favor of a more general authority for the Commissioner. This would permit the Commissioner to respond in a more timely manner to emerging priorities as they are identified by the network; and is consistent with the Administration's request for lesser funding under Title IV in order to perserve the level of services funds under Title III. We believe that great progress has already been made in activities which have in the past been funded and that many of the outcomes of such activities can be shared with the network through an increased emphasis on dissemination. Also, we believe that through leveraging, the limited Title IV funds can be used to gain commitments from other agencies and private organizations in the public and private sectors. This leveraging is most readily accomplished when the Commissioner has greater flexibility in terms of how to use Title IV funds.

N4A PROPOSAL - MANDATED USE OF DATA BASE

QUESTION: The proposed language for the 1984 reauthorization of the Older Americans Act developed by the National Association of Area agencies on Aging includes a requirement for section 421, which deals with research and development projects, to the effect that grantees under that section be required to use the National Data Base on Aging to the maximum extent possible?

Does the Administration have a position on this proposal?

ANSWER: We do not think it would be in the best interest of all concerned to impose a statutory requirement regarding the use of the data base. The Administration on Aging supported the development of the National Data Base on Aging and continues to assist the further refinement of the capacity of the data base. It is a useful resource which can be of great benefit to those who have need for the types of data which it can provide. However, we believe that the data base should stand on its own merit and the contribution which it can make to those who are interested in research and study of the aging network.

DIRECT FUNDING OF AAA'S TO PROVIDE EDUCATIONAL AND TRAINING ACTIVITIES

QUESTION: National Association of Area Agencies on Aging has also proposed that education and training funds go directly to Triple-A's. Do you have a position on this?

ANSWER: The Administration would not be supportive of N4A's proposal. The Administration's proposal would revise Title IV to make it less restrictive and more workable, and responsive to the needs of older individuals. This would continue the direction established by the 1981 amendments to increase flexibility under these discretionary programs. Such flexibility is necessary for AoA to be in a position of responding to emerging priorities as they are identified. The proposal would continue to provide authority to the Commissioner to directly make grants and contracts.

Senator PELL. Thank you very much indeed, Madam Commissioner. As you know, our subcommittee has scheduled a markup for the Older Americans Act in late March. Will you give us some idea of whether we will have an administration bill up by then or not? If we do not, we obviously will go ahead.

Dr. TOLLIVER. At this time, Senator, I would say that we hope to have the bill up here shortly. It is currently undergoing departmental review.

Senator PELL. Then you have an actual draft that is going through department review?

Dr. Tolliver Yes, we have.

Senator PELL. Maybe the thought that we will mark up our own bill may spur that review on more quickly, hopefully.

Dr. TOLLIVER. I will certainly transmit that to the officials in the Department.

Senator PELL. Thank you. Now, as Senator Grassley mentioned in his opening statement, there have been complaints for some years about inadequate dissemination and utilization for title IV projects.

What have you done, or what steps have you taken to facilitate dissemination of research and demonstration reports?

Dr. TOLLIVER. The Administration on Aging, in April 1983, was reorganized and at that time an Office of Technical Information and Dissemination was developed. We recently completed the draft of a comprehensive dissemination strategy that we expect to share with appropriate persons, including the National Aging Leadership Council, persons within our Department, and interested Members of the Congress. Then we will proceed with the implementation of that particular program.

In addition, in the 1984 discretionary award proposals, we had a section that focused on dissemination. So we have had applicants submit concept papers to facilitate our dissemination efforts.

We have concluded a major agreement with the American Association of Retired Persons to continue the information system that we had developed. They are now calling the system AgeLine. They will maintain the public use data base, including both bibliographic and research information. And as we complete products within the Administration on Aging, we will be referring those products for listing within that particular system.

Senator **Pell**. What do you mean by "products?"

Dr. **Tolliver**. Products could be findings from demonstration programs, research findings, and reports that come in from our grantees on model projects. That information would be available to others through the Age Line system.

We also have submitted materials to the National Technical Information Service through project Share, which is a clearinghouse that is sponsored by the Department of Health and Human Services, and persons will be able to access materials through that particular program.

Senator **Pell**. Thank you. Are you able to comment on H.R. 4272 or S. 2221, which are identical bills that would place in this title IV that we are holding the hearing on today various activities relating to help for those suffering from Alzheimer's disease or helping those who suffer from it?

Dr. **Tolliver**. Senator, the administration's basic position is that we would like to have the title IV section of the Older Americans Act be given more flexibility, so we would not support specifying activity in the area of Alzheimer's disease.

To indicate the extent to which we, too, are aware of the problem and are concerned about it, I would call to your attention the fact that the Administration on Aging's 11 long-term care gerontology centers for the past several years have been in the process of developing materials to be used by patients as well as family members in the area of Alzheimer's disease.

These centers, as well as the Health Policy Study Center that we support at the University of California or San Francisco, are currently putting together a document for us that we will be able to distribute to the aging network which focuses on the development of family support groups.

There have been 13 applicants who have submitted concept papers related to Alzheimer's disease within our current discretionary program. In addition to the activities in which the Administration on Aging has been engaged, the Secretary approximately a year ago identified Alzheimer's disease as one of her priority areas.

I served on the task force that prepared a comprehensive report which is now under review by the Secretary, and the report covers all of the areas in terms of services, research, and training. In addition to the Administration on Aging, we find that the National Institute on Aging, the National Institute of Mental Health, and the National Institute of Neurological Communicative Disorders and Stroke also have initiatives related to Alzheimer's disease.

So, at the present time, the funding within the Department for components related to Alzheimer's disease is in excess of $32 million.

Senator **Pell**. Well, just to be specific and maybe a little more brief, as I understand it, you do not advocate putting in specific reference to assisting those suffering from Alzheimer's disease, is that correct?

Dr. **Tolliver**. That is correct.

Senator PELL. But would you consider that the legislative history of the bill should show that assistance for those suffering from Alzheimer's disease, and research in this field, could be undertaken under title IV of the bill?

Dr. TOLLIVER. As it exists at the present time—and that was the reason I was telling you some of the activities that are currently underway—we do not feel we need that authority; that it already exists within the act.

Senator PELL. Thank you. In your earlier statement, you called for the deletion of some of the special projects authorized under the act. Could you give us a status report as to what has been provided already or accomplished under those provisions of the act so we might make an informed judgment as to whether to delete those provisions?

Here, I have in mind a written statement you could submit to the subcommittee a little later on.

Dr. TOLLIVER. Yes. By taking this action, as Commissioner I would be able to respond in a more timely manner to emerging priorities as they are identified by the network and by older people themselves, and certainly by the Members of Congress.

It is also consistent with the request for a reduced funding level in order to preserve the level of service funds under title III. We believe that great progress has been made in activities which have been funded in the past, and that many outcomes of such activities can be shared with the network through an increased emphasis on dissemination.

We also believe that through leveraging resources of other agencies that we would be able to continue the high quality of the discretionary program.

[The following was received for the record:]

Title IV of the Older Americans Act, as Amended, authorizes a program of discretionary grants and contracts to support training and education, research and demonstration, and other activities. The primary purpose of these activities is to develop the necessary knowledge and information base to assist AoA and the State and Area Agencies on Aging to carry out the goals, objectives, and program services set forth in the Act. A total of $22,175,000 was available to support those efforts during FY 1983. This section describes the AoA activities during FY 1983 for Title IV, Part A--Education and Training, and Part B--Research, Demonstrations, and Other Activities. This section also includes a description of the major long-term care initiatives undertaken by AoA in FY 1983.

The Administration on Aging participated in the Office of Human Development Services FY 1983 Coordinated Discretionary Funds Program. This program provides opportunities for efforts which crosscut OHDS programs. A total of 76 new awards were made for grants in education, training, and demonstrations under this OHDS program.

A. Title IV-A--Education and Training

Section 411 of the Act authorizes the award of grants and contracts to assist in recruiting persons to enter the field of aging, training volunteers and persons employed in or preparing for employment in the field of aging, to provide technical assistance, and other activities related to such training. In FY 1983 a total of $5,681,497 was available to support education and training under this section of the Act. A brief description of major activities is presented below:

- State Education and Training Program: This program provides funds to each State Agency on Aging to support training and technical assistance to improve the knowledge, skills and performance of State and Area Agency and service provider staff. States determine priority training needs and submit training plans based on their needs. States then receive grants to maintain and improve the competency of persons working in the field of aging. AoA provided support in the amount of $2,244,009 to State Units on Aging in FY 1983.

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- Gerontology Career Preparation Program: This program is focused on the development and improvement of academic instruction programs for specialized training of personnel in human service and multidisciplinary occupations and professions that service or primarily benefit older people. In one element of this program emphasis is on activities which support curriculum and faculty development, didactic and field practicum course development and enrichment, coordination of student placement, and liaison and interchange of activities with aging agencies and sevice organizations. In this element of the program there were three new projects totaling $212,625. and one continuation which received $5,000 in FY 1983.

  A second element of this program addressed the allied professions, particularly professionals employed in the fields of housing, employment and health, whose daily decisions impact seriously on the well-being of older persons. The activities funded under this category were designed to stimulate and support education and training within associations in these allied professions. AoA sought to stimulate professionals' interest in the needs of older persons and to promote their utilization of current knowledge. In FY 1983, twenty-eight projects were funded in the amount of $1,908,586.

  A third element consists of the Historically Black Colleges and Universities (HBCU) Initiative. The purpose of this initiative is to develop innovative techniques to increase the capacity of HBCU's to provide quality self-help education to older persons in the areas of housing, employment, transportation and health promotion. In addition, the participating schools are developing methods for establishing and maintaining linkages between HBCU's and private sector organizations. Six awards totalling $399,658 were made to HBCU's in FY 1983. Four projects funded in FY 1982 continued.

- Technical Assistance: In FY 1983, under contract with AoA, the Community Nutrition Institute of Washington, D.C., technical assistance was provided to 525 State Unit on Aging, Area Agency on Aging, and local service provider staffs in: 1) cost containment; 2) management; 3) home-delivered meals; 4) staff development; and 5) community resource development. This effort received funds in the amount of $53,254 in FY 1983.

  In another effort on-site technical assistance was provided to Indian aging projects funded under Title VI of the Older Americans Act. Also three days of training were provided to the eighty-three tribal grantees on the existing operations manual. In

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addition, the contractor developed supplemental materials for the operations manual. In FY 1983, ACKCO, Inc., of Boulder, Colorado, received $181,435.

- National Continuing Education and Training Program: This is a multi-year national training and technical assistance program designed to develop and disseminate instructional materials, including self-instructional activities for practitioners in the field of aging. Training programs funded under this program emphasize improvements of services provided through the Act. Two projects were funded in FY 1983 in the amount of $320,033. One project has designed, developed, and implemented the Older Adult Services and Information System (OASIS) and the second is providing training to State Unit and Area Agency staff on ways to increase project efficiency and increasing contributions from project participants.

- Minority Management Training Program in Aging: The purpose of this program is to increase recruitment, training, and placement of minority individuals in the field of aging. In FY 1983 AoA awarded a grant in the amount of $349,897 to the National Center and Caucus on Black Aged (NCBA) for training of minority individuals (Native Americans, Hispanics, Blacks and Asian/Pacific Americans) by placing them in participating host agencies within the aging network and private sector agencies.

- Minority Research Associate Program: The purpose of this program is to recruit minority social scientists to conduct aging research. In FY 1983 AoA supplemented by $7,000 a previously awarded grant.

B. Multidisciplinary Centers of Gerontology

Title IV-A, Section 412 of the Act authorizes the award of grants to public and private nonprofit agencies, organizations, and institutions for the purpose of establishing or supporting multidisciplinary centers of gerontology, and gerontology centers of special emphasis, for example long-term care.

1. National Policy Study Centers

In FY 1983 AoA continued three national policy study centers in the areas of income maintenance, health, and

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employment, which were originally funded in FY 1980. These three national policy study centers received new funding during FY 1983 of $775,149. During the past year the centers were engaged in policy analysis and development; policy research; and the preparation of personnel for undertaking work in these areas and for teaching these skills to others. Another important task was to respond to a limited number of requests from AoA for assistance. Typically, these requests involved policy analysis.

A fourth policy study center on housing received $28,501 in FY 1983 to complete a comprehensive framework on housing policy issues begun in the previous year.

The subject matter, location, activities and key products for the policy centers during FY 1983 are listed below:

- Center on Income Maintenance Located at Brandeis University

  The Center in FY 1983 worked on: (a) The Relationship Between Social Security and Other Pension Benefits, an analysis to clarify and quantify the impact of integration between social security and other pension benefits on Black and Hispanic older persons; (b) Special Corporate Retirement Benefits, a study of the impact of one corporation's retirement incentive scheme and development of an overview of the different structure of special corporate retirement benefits, issues involved in implementing them, and the feedback and consequences of implementation for both corporations and retirees; (c) Access to Appropriate Services: Income, Demand, and Supply as Dimensions of Transportation Policy Development, an analysis that focuses on the interplay of transportation demand and supply with the income status of subgroups within the older population, the comparative advantages and disadvantages of moving services versus moving people, and the profile of future policy issues that are likely to emerge in the context of demographic and economic trends; (d) Implication of Regional Mobility for Targeting Policies to Subgroups of Older Persons, an examination of the impact of continuing migration by older persons (particularly with respect to income and labor force participation characteristics); (e) Issues Involved in the

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Implementation of Targeting Strategies, an examination of the issues involved in choosing among the various characteristics that can be used to define subgroups for targeting; and (f) Dissemination of the Policy Framework on Income Maintenance, a policy framework to provide a concise overview of major issues, problems, and potential remedial actions that bear upon income maintenance policies affecting older persons.

- Center on Health Located at the University of California - San Francisco

  The Center in FY 1983 worked on: osteoporosis/hip fracture; arthritis; sensory limitations; health promotion; low-income, isolated elderly; health maintenance organizations/social health maintenance organizations; employment, retirement and health; and board and care policies.

  For each of these conditions, a literature review was undertaken, to assess causality along a variety of medical, social, environmental, and life style dimensions. Existing interventions, resources, and programs designed to address the condition was inventoried and evaluated along with their actual or expected impacts on each condition. Emerging from this evaluation will be a series of specific policy options designed to address problems areas for consideration by AoA in the formulation of its Health policy and research strategies.

  During FY 1983, the Center also expanded previously prepared policy papers on exercise, nutrition, and drug education to address several additional substantive areas including: women's issues, rural issues and minority issues.

- Center on Employment Located at the University of Southern California

  The Center in FY 1983 worked on: (a) Older Americans and Employment, an employment strategy developed for and in collaboration with the Administration on Aging; (b) Low-Income Older Workers, an analysis of the working poor, which will include a view of this subpopulation in terms of their own self-reliance and self-sufficiency; (c) Older Workers and Productivity,

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an empirical analysis of productivity differences by age using employer-based measures of productivity; and (d) Health, Aging and Work, (in collaboration with the Policy Study Center on Health at the University of California, San Francisco) analyses of the following issues: the demand for health and the retirement decision, work disability under conditions of improving life expectancy, age and employer health care cost, and age, health and productivity.

2. Long-Term Care Gerontology Centers

The Long-Term Care Gerontology Centers are also funded under Title IV-A, Section 412. The Centers are discussed in the Long-Term Care section of this report.

C. Title IV-B Research and Development

Title IV-B Section 421, Research and Development, authorizes funds to identify and assess new approaches and methods for improving the life circumstances of older persons. The primary objective of AoA-supported research is to develop new knowledge that will increase the capacity of State and local agencies, in both the public and private sectors, to assist older Americans in achieving and maintaining economic and personal independence. Thus, the research program emphasizes collection and analysis of information on policies and programs affecting older persons; the development of innovative programs to improve the lives of older persons; and the dissemination of these findings and results for use in serving older persons, particularly by the Aging Network. In FY 1983, a total of $642,305 was allocated to initiate nine research and development projects and to continue one project. In addition, twenty other research and development projects were operational with funds from previous years.

These new and continuing research and development projects are categorized and described below under five priority subject areas:

- Housing and Living Arrangements: Two new research and development projects, totaling $158,355 in this area include one to develop a elderly consumer guidebook on housing options and another to develop and apply instruments to be used in urban areas for assessing community elderly housing. Both the guidebook and assessment instruments will be disseminated widely with the purpose of increasing the housing choices of older persons.

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Ongoing projects in the housing and living arrangements area cover several important subjects. In the field of congregate housing, under an interagency agreement between the Administration on Aging and the Farmers Home Administration, nine model congregate housing facilities for the elderly in selected rural sites have been established under the jointly sponsored National Congregate Housing Program. AoA funding in prior years of the nine current projects totals $1,175,550. In addition, a project in Massachusetts at a budget level of $180,000 from last year's (FY 1982) funds is examining the effectiveness of elderly congregate housing programs and the characteristics of seniors who adjust to the congregate housing setting.

In related housing areas, one project is testing the feasibility of transferring the ownership of facilities housing older persons and other residents from absentee landlords to tenant organizations or cooperatives. A second project is developing fire safety education programs for older homeowners, and a third proposed a strategy for the development of training and management tools for the managers of housing facilities designed for older occupants. These three projects were funded in prior years at a total of $255,570.

- Income Generation: Three projects have been funded to develop and promote the use of home equity conversion by older persons as a means of generating needed income while continuing to live independently in their own homes. These projects have a total budget of $417,791 of which $147,000 has been awarded in FY 1983 for a new project for the dissemination and utilization of educational and training materials on reverse mortgages, sale leasebacks, and other home equity conversion instruments. A project that deals with developing public understanding of home equity conversion received $1,520 in FY 1983 funds.

- Community-based and Family-based Care: Three ongoing research and development projects deal with improving community-based and family-based care for older persons. Two projects totaling $328,281 of AoA support from last year (FY 1982), focus on the Wisconsin system of long-term care for the elderly. One project analyzes the use of vouchers by older consumers in making effective choices of long-term care services.

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The second project evaluates the Wisconsin Community Options Program, which attempts to transfer substantial authority for the provision of long-term care from the State to the local level. The third project, funded previously at a level of $153,742, is developing a reliable set of measures of elder abuse for use by agencies working with older persons, along with a package of training materials in the use of the index.

- Improved Management of Nutrition and Supportive Services Programs: Four new projects, totaling $232,625, were funded in FY 1983 for the purpose of improving State and local management of aging projects. One is designed to evaluate the impact of a fee structure on the utilization of the Illinois Community Care Program for the elderly. The second project will develop a decision model for targeting scarce resources on the basis of which services contribute most to the self-sufficiency of older persons. The third project is developing and implementing an evaluative framework that will provide program managers with reliable data on the functioning of an integrated service delivery network. The fourth project is testing a technology for measuring and improving the efficiency of human service programs.

  Ongoing projects in this area include the support (jointly with the National Institute on Aging) of a national archive of computerized data on aging, which received a supplemental award in FY 1983 of $20,000; and an assessment of a program of human services block grants transferred to county government which received initial AoA funding in FY 1982 at a level of $100,000.

- Voluntarism Program: Two awards were made by AoA in FY 1983 totaling $82,805 in the area of voluntarism programs which assist older persons. The first will develop a computerized data system on volunteer programs in New York City, and the second will examine the effectiveness of peer volunteers in giving assistance to partially sighted older persons.

  One other continuation project in this field funded in FY 1982 for $179,266 is developing, testing, and documenting effective practices for recruiting, retaining, and managing volunteers in aging services programs.

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D. Title IV-B Demonstration and National Impact Projects

Title IV-B, Section 422, authorizes the award of grants or contracts to support model projects which demonstrate methods to improve the well-being and independence of older persons. The program seeks to test and demonstrate effective new mechanisms, systems, or approaches for providing and delivering services. The program is also designed to improve the coordination and quality of social and other services for older persons, to facilitate the exchange of information, and to assist in the national use of project findings. Section 424 authorizes the award of grants to provide support to State and Area Agencies on Aging to develop and provide legal services and demonstration projects to expand or improve legal services to older persons with social or economic need. Section 425 authorizes the award of grants or contracts to support innovation and development projects of national significance which show promise of having substantial impact on the expansion or improvement of services, or multipurpose senior centers or otherwise promoting the well-being of older persons. AoA invested $7,359,146 in FY 1983 to support new and continuing demonstration and national impact projects.

- FY 1983 Continuation Projects: In FY 1983 forty-two previously funded projects continued to function during all or part of the year. Thirty-two of these projects received continuation funding in FY 1983. The following are examples of current projects:

  - National Organizations - Projects in this category are designed to promote a better partnership between AoA, national organizations, and the aging network to improve capacity to plan for and deliver services to underserved older persons. Four national organizations which represent minority populations received funding during FY 1983. Two other awards were made to organizations serving the older population in general. These six national impact awards totaled $1,504,375 in FY 1983.

  - Legal and Ombudsman Services - In FY 1983 AoA continued to provide grants from Title IV in the amount of $2,852,020 (this amount is not included in the total shown above) to State Agencies on Aging to support the establishment and development of State long-term care facilities ombudsman programs. In addition, the States spent $3. 8 million from their

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Title III-B allocations to operate the State ombudsman programs. AoA also funded two legal services projects for older persons, totaling $150,000.

- Program Management Improvements - There are five projects in this area. Four projects are in their final phase of fostering the development of State and local systems for improving data collection, storage, reporting and computerization of data pertaining to aging programs. Another project focuses on the development of management indicators to improve State administration and local service delivery. The funding level for FY 1983 was $193,582.

- Services in Rural Areas - In FY 1983 AoA continued support of five projects in the amount of $249,241 for services in rural areas. They are designed to demonstrate models for effective linkages, joint planning and coordination with other local institutions and organizations. The projects will demonstrate how rural Area Agencies on Aging can perform a catalytic role in the community and obtain support to carry out improved programs in conjunction with other public and private organizations at the local levels.

- Voluntarism - AoA continued to support projects to stimulate voluntarism. Two projects received continuation awards totaling $173,474 in FY 1983. The first is the National Voluntary Organizations for Independent Living for the Aging (NVOILA) project, which stimulates national voluntary organizations to encourage and help their local units develop and carryout new programs to help older persons in their communities. The second project analyzed research and practice materials on volunteers and natural support systems and developed guidance for more effective use of volunteers in service to Hispanic older persons.

- Elderly Abuse and Mental Health - In FY 1983 AoA continued the support of the last phase of three projects which are examining the extent of elder abuse, identifying mechanisms for treatment and prevention, and exploring ways in which traditional protective services can be enhanced and coordinated with other social services to provide

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services for older persons who are at risk of abuse. The total funding in FY 1983 was $221,893. AoA continued two projects funded previously to improve mental health services for older persons. These efforts focus on enhancing and increasing coordination between mental health and aging agencies at the State, regional and county levels, and facilitating linkages among local providers of mental health and aging services.

- Services to Minorities - The five projects in this area continue to focus on improving the capacity of Area Agencies to serve minority older populations and improve services to minority clients. These projects received additional funds in FY 1983 totaling $311,935.

- Public Policy Options - The three policy options projects continued to encourage the use of government's broad powers (local, State and Federal) to solve human service problems without relying unnecessarily on direct use of public funds. Public policy options (also referred to as "indirect services" and "governance") are a supplement to direct delivery of services. SRI International, the National Association of Counties, and the U.S. Conference of Mayors received a total of $308,509 in FY 1983 to strengthen the role of State Units and Area Agencies in implementing indirect services.

  Eight specific sites have been receiving technical assistance from the three organizations to develop policy options programs in the areas of housing, employment and long-term care.

o FY 1983 New Projects: Fifty-three projects, including projects funded jointly with other agencies, received awards in FY 1983. The following examples indicate the types of projects undertaken:

- Employment and Income Generation - Six new projects were funded in FY 1983 totaling $410,276 to increase the economic self-sufficiency of older persons. These projects focus mainly on promotion and provision of employment opportunities to enable older persons to enter or remain in the job market or to assume positions not traditionally held by older workers.

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- Program Management Improvements - AoA made eighteen new awards in this general area totaling $1,511,905 in FY 1983. Twelve of these awards, totaling $920,885, support the development of State and local systems for improving the collection, reporting and utilization of data. These improvements, which generally involve the use of modern computer technology, will serve to improve targeting of resources, increase utility of information available, provide information to administrators and decision-makers for decisions on policy, budget, administration, client tracking, and monitoring of agency performance. One of the projects will integrate uniform service definitions, as a standard, into existing computer information systems and replicate this approach as a cost-effective means of achieving compatibility in reporting. The remaining group of six awards, in the amount of $591,020, support the improvement of management practices by developing performance-based contracting and evaluation, group purchase models, cost containment in home care and service system assessment procedures.

- Intergenerational Relations - Two projects were funded totaling $145,199 in FY 1983. One project is designed to enhance the capacity of neighborhood centers to initiate and develop programs between the generations, especially with low-income, isolated, minority elderly. The other project is developing models of service-learning programs to demonstrate how non-traditional service organizations can assist in the delivery of services to the elderly.

- Targeting Resources - In FY 1983 six awards were made in the amount of $592,686, which continue AoA's past efforts to develop products and strategies for improved resource allocation and services to special populations. Examples of targeting projects funded include a consortium of organizations that is developing strategies to enable Area Agencies on Aging to improve services to minority elderly; another project is providing assistance to States in developing micro-computer simulations of the Intra-State Funding Formula to serve persons in greatest economic or social need; and another project is focusing on visually impaired older persons by linking consumers, clinicians and the aging network at five demonstration sites.

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- Community-based and Family-based Care/Prevention and Intervention Strategies - In FY 1983, six grants totaling $343,029 were awarded to projects demonstrating effective primary prevention and intervention strategies and ways to increase the use of families and informal support networks to reduce dependency on social services. These projects focus on maintaining the self-sufficiency of older persons through youth volunteers, developing models for respite care and providing hospice services.

E. Long-Term Care (LTC)

The Older Americans Act assigns AoA the responsibility to participate in departmental and interdepartmental activities which concern issues of institutional and noninstitutional long-term health care services development. The 1981 Amendments to the Act broadened the long-term care responsibility of AoA and State and Area Agencies on Aging to include "board and care homes" of the type covered by the "Keys Amendment" to the Social Security Act. In FY 1983 AoA spent a total of $4,608,065 (including $1,890,000 for evaluation of the Channeling Demonstration) to initiate new projects and continue previously funded long-term care (LTC) projects.

AoA's long-term care activities support the improvement of policies, programs and systems which enhance the opportunity for functionally impaired older persons to secure and maintain maximum independence and self-sufficiency. The mission addresses basic goals of the Department--to serve those most in need--as well as the goals of AoA--to ensure that services or other appropriate assistance is available to those older persons in need. The major thrust of the long-term care initiatives is to help maintain older persons in the community and to the extent possible in their own homes. AoA is concerned with developing more effective and less costly solutions for problems resulting from a rapidly increasing functionally impaired older population and from the escalating costs of health care, personal care and social services which already exceed available public resources. These initiatives support State and Area Agencies in planning, coordinating and managing services intended to address the problems of highly vulnerable older persons. AoA's long-term care activities are:

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1. National Long-Term Care Initiative: This Departmental initiative is aimed at developing a knowledge base drawn from research studies and demonstration projects to serve as a foundation for policy and program development and capacity building at the State and local levels. AoA is participating in this initiative along with the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. In FY 1983 AoA supported this initiative with $1,890,000 of Title III funds for the National Channeling Demonstration Evaluation. This initiative is comprised of the following interrelated components:

   a. Long-Term Care Analysis Project

      1. Report received from the Urban Institute contained an analysis and synthesis of existing LTC data to make estimates of the distribution and mix of impairments; the supply, utilization and cost of formal and informal services; and the outcomes of LTC services.

      2. The U.S. Bureau of Census is completing the editing of the final stages of the data tapes on a national household survey to determine the incidence and extent of functional impairment among persons 65 and over, and the need, demand, and utilization of health care, personal care and social services.

   b. Channeling Demonstrations

      The purpose of these demonstrations is to develop organizational structures and operating procedures at the community level to match resources with identified needs for various types of continuing care. The demonstration sites are also provided technical assistance with the planning and implementation of their activities. Evaluation of process and outcomes is a major part of the demonstration effort.

      The LTC Channeling Demonstration Program is testing different models for linking older persons with appropriate types of long-term care at community-level sites. Five of these sites are experimenting with a "case management" model while

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another five are using a "financial control" model. These two models share a core set of functions: outreach, screening, comprehensive needs assessment, care planning, and case management (arranging for services, monitoring, and reassessment).

The two models diverge in several important respects: their authority to arrange for services, their reliance on the existing services and public programs, and their approach to cost containment. The "case management" model, through the core functions cited above, relies on the case manager to negotiate access to existing services and to make efficient use of them. The "financial control" model, in contrast, confers authority on the case manager to authorize and purchase services out of a pool of funds without respect to many important existing program requirements, such as income eligibility. It does, however, impose strict controls on costs through caps on program and individual expenditures, and requires cost-sharing by clients with higher incomes.

The caseload target for each of the ten Channeling Demonstration sites has been reached and each site is fully operational. An evaluation interim process analysis report has been published and disseminated.

2. Long-Term Care Gerontology Centers: By mobilizing the resources of a number of universities and collaborating with community-based public and private sector agencies, the Centers with support from AoA undertook the following programmatic activities:

   a. development of professional and paraprofessional staff for the delivery of health care, personal care and other services through career and continued education and training;

   b. development of applied and clinical research to improve conditions for the functionally impaired older persons;

   c. development and evaluation of models for the provision of long-term care; and

   d. information dissemination and technical assistance to State and local public and private agencies.

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In FY 1983, two more Centers were funded in the amount of $699,523 which completes the plans for establishing one Center for each of the ten DHHS Regions. The two Centers are the University of Utah at Salt Lake City (Region VIII) and the University of Texas at Dallas (Region VI). In addition four Centers were refunded at a total of $2,018,542.

Each of the LTC Gerontology Centers is serving as a resource in its respective Region for State and local public and private agencies engaged in or planning services to functionally impaired older persons in their homes and in alternative living arrangements, including institutions. The centers are establishing a two-way working relationship with State and Area Agencies in planning for, development of, or changes to existing long-term care systems. As a part of this effort, the centers are providing technical assistance to the Aging Network on long-term care issues and concerns.

Through research, education and service activities involving university faculty, agency planners, managers and practitioners, these Centers assist their local community, State and region in developing and implementing more cost-effective and efficient long-term care policies, programs and systems. Centers serve as major resources to State and community agencies in efforts to address the long-term care needs of older persons.

Many of the Long-Term Care Gerontology Centers have been involved in developing new approaches to address the problems of Alzheimer's Disease. In particular, the Centers have been active in the development of model support group for families and for the development of a model to train service providers to work with caregivers of dementia patients. Several research efforts have begun to look at the impact of Alzheimer's Disease and related dementias on the role of the family. Other efforts include the establishment of a network of Alzheimer's Support Groups and a forum to facilitate information exchange on Alzheimer's Disease among lay and professional people.

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FY 1983 TITLE IV DISCRETIONARY BUDGET

ADMINISTRATION ON AGING

Education and Training	$ 5,681.497
Multidisciplinary Centers of Gerontology*	803,650
Research and Development	642,305
Demonstrations	7,359,146
Long-Term Care Projects	4,608,065
Legal, Protective and Ombudsman Services	2,852,020
Disaster Assistance	65,315
Miscellaneous Costs	163,002
TOTAL	$22,175,000

*Funds for the Long-Term Care Gerontology Centers are shown under Long-Term Care Projects.

Senator PELL. Thank you. Madam Commissioner, we would like to have for the record a description of the way the coordinated discretionary program works at this time. Is that convenient to provide here?

Dr. TOLLIVER. Yes. I would defer to Mr. Torrado on this.

Mr. TORRADO. Senator, if I may, I have a few charts that will explain how we award the grants.

Senator PELL. All right. Without objection, these charts will be included in the record, too.

[The charts referred to follow:]

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OFFICE OF HUMAN DEVELOPMENT SERVICES
Coordinated Discretionary Program
A Summary

In 1982 the Office of Human Development Services (HDS) initiated a new approach to awarding research and demonstration funds in the field of human services. Called the Coordinated Discretionary Program (CDP), this approach increases the benefits obtained from nine separate discretionary programs by coordinating their grant making activities. Funds are administered in accordance with the specific authorities governing each individual program, and used for their legislatively established purposes. The programs which participate in the CDP and the dollar amounts* (in thousands) of grants made by each are:

	FY 1982	FY 1983	FY 1984**
Head Start	$ 3,925	$ 1,969	$ 2,500
Child Welfare Services	4,030	4,440	5,000
Child Abuse Prevention	2,325	1,906	7,000
Adoption Opportunities	1,590	1,423	1,500
Native Americans	599	927	700
Developmental Disabilities	2,014	2,401	1,500
Social Services Research	2,828	2,772	2,000
Older Americans	6,040	6,680	5,500
Runaway and Homeless Youth	-0-	3,598	3,800
Total	$23,351	$26,116	$29,500

Funds from each program are tracked separately, even where projects receive awards from several programs. For instance, if the Commissioner on Aging and the Commissioner of ACYF decide to jointly fund a project, both Commissioners and their respective program and budget officers must approve the award, appoint project officers, and track the two awarded amounts separately.

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* Not all discretionary funds appropriated by Congress for these programs are coordinated through the CDP. For example, of $21.5 million appropriated by Congress in FY 83 for the Runaway Youth program, $3.6 million were awarded under the CDP to runaway youth service improvement demonstration projects. The remaining $17.9 million were awarded under a separate program announcement independent of the CDP.

** FY 1984 figures represent ammounts projected to be available.

Under the CDP a single program announcement is published annually in the *Federal Register* describing priority areas selected for funding, selection criteria, basic requirements and application instructions. Priority areas are selected through a detailed planning process that involves every program official in HDS, State officials and major national organizations representing the populations served by HDS. Priority areas are intended to expand the boundaries and utilization of human service knowledge (not to support service projects) and represent the consensus of Program Commissioners and the Assistant Secretary for Human Development Services (ASHDS).

Potential applicants have 60 days from the date the announcement is published to submit a 10 page preapplication to the program. Some 3,000 preapplications are received each year and are screened by HDS staff to assure conformance with basic requirements, such as maximum length and required grantee match. Preapplications that meet all the screening requirements are scored by at least 3 field reviewers who are selected for their expertise, and who are not, in most cases, Federal employees. These reviews are organized around individual priority areas to assure competition only among similar preapplications. The results are submitted to HDS Senior Staff (the ASHDS, Program Commissioners and Staff Office Directors) who discuss preapplications individually and select approximately 500 to be invited to submit a full application.

Finalists have 35 days to submit a full application. Once received, applications are evaluated by 3 to 5 reviewers. In a few cases final applications are subjected to an administrative review by Federal Staff when Senior Staff decides that the concept paper is unique or exemplary. The results of this evaluation are submitted to Senior Staff who again discuss every project under consideration and make the final selection of some 200 to 225 grantees (Figure I summarizes this process).

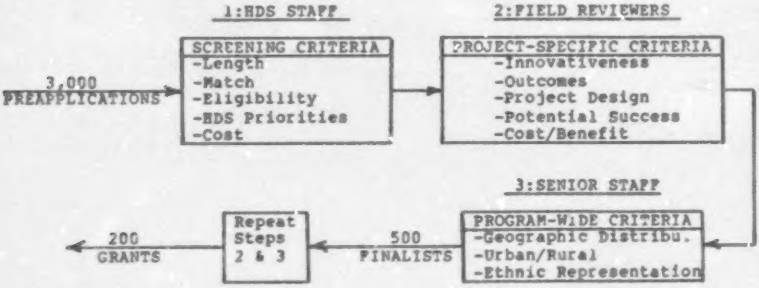
1:HDS STAFF
2:FIELD REVIEWERS
3,000
PREAPPLICATIONS
SCREENING CRITERIA
-Length
-Match
-Eligibility
-HDS Priorities
-Cost
PROJECT-SPECIFIC CRITERIA
-Innovativeness
-Outcomes
-Project Design
-Potential Success
-Cost/Benefit
3:SENIOR STAFF
PROGRAM-WIDE CRITERIA
-Geographic Distribu.
-Urban/Rural
-Ethnic Representation
500
FINALISTS
Repeat
Steps
2 & 3
200
GRANTS

FIGURE I: REVIEW AND SELECTION PROCESS

An immediate benefit of this coordinated approach is that HDS now has a formal mechanism to address areas of concern that involve several programs. For example, the problem of independent living for developmentally disabled youth as they become adults can now receive coordinated attention from the Administration for Developmental Disabilities and the Administration for Children, Youth and Families. Before the CDP it would have been difficult for either program to adequately address issues related to multi-problem youth.

Another advantage is that projects that benefit several populations can be jointly funded at a lower total cost because duplication is eliminated. A prime example of this is the CAL-COMP project in San Mateo County, California, which is developing computerized information systems for fiscal management, client/service data reporting and volunteer resource management for local agencies serving the elderly, the developmentally disabled and Head Start children. Through the CDP, HDS was able to fund one project for $225,000 rather than three projects totaling $450,000 for separate (and incompatible) computerized information systems. This coordination increases the impact of CDP funds by over 36%. Moreover, when the required grantee match is considered, there is an estimated impact of almost twice the Federal investment.

The CDP has also increased internal efficiency. Analyses by the Grace Commission and the Office of Management Services in HDS demonstrate that the CDP has reduced the work required to award discretionary grants by 73 person-years, an increase in operating efficiency of almost 300%. Nevertheless, each applicant still receives an average of over 23 hours of staff work with increased attention by Senior Staff.

In addition, by initially requiring only a 10 page preapplication instead of a full application, the CDP reduces the applicant's cost of competing by over 83%. It also allows smaller, community-based organizations with good ideas but weak proposal-writing skills to compete on a more equal footing with large organizations. Indian tribes, community-based organizations and nonprofit organizations (other than colleges or universities) received 63% of all CDP grants in FY 83 compared to less than 30% for the equivalent programs in FY 80.

As with previous programs, the CDP uses field reviews as the primary factor in a selection process that takes into account other factors such as urban/rural balance, geographic distribution and ethnic representation. Unlike the previous process, however, final decisions are made only after consultation among Senior Staff, rather than by one program official in isolation. This process -- explained in the program announcement -- promotes more informed and coordinated decisions, while assuring full discussion of every selection. HDS Senior Staff, by discussing every application, are able to apply program-wide criteria such as geographic distribution--something which would be impossible for field reviewers since each reviewer only sees

15 to 20 applications.

The influence that reviewers' scores have on the selection process remains strong, however. Sixty-four percent of funded applicants ranked in the top 20% of reviewer scores (See Fig. II) and only 3.5% of CDP funds were used to fund projects ranking below the 50th percentile.

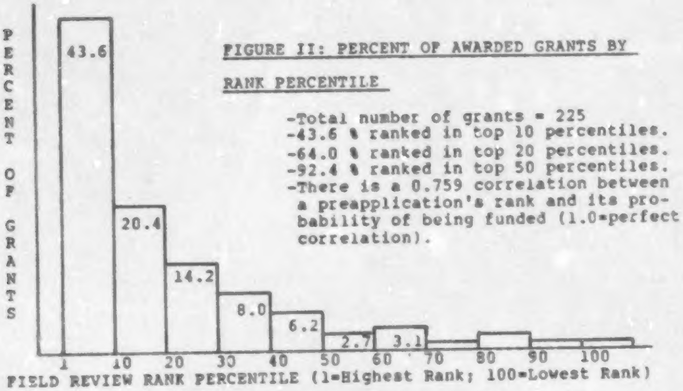

FIGURE II: PERCENT OF AWARDED GRANTS BY RANK PERCENTILE

- Total number of grants = 225
- 43.6 % ranked in top 10 percentiles.
- 64.0 % ranked in top 20 percentiles.
- 92.4 % ranked in top 50 percentiles.
- There is a 0.759 correlation between a preapplication's rank and its probability of being funded (1.0=perfect correlation).

As noted in Figure II, a small percent of low ranked applications are funded*. Typically, these applications propose low cost/high risk innovative ideas that, if successful, could make major contributions to solving a specific problem. Examples of such projects are: an attempt to use an upcoming World's Fair to generate employment for inner city welfare mothers; a project to generate income for Alaskan Natives through the sale of artwork created during the winter months of inactivity. These projects were funded instead of others which may have been more highly ranked but which reflected approaches or ideas which have been applied numerous times before.

The Coordinated Discretionary Program has met or exceeded its objectives. It has provided an innovative and efficient mechanism for addressing research and demonstration issues common to all HDS programs, while retaining the legislative purposes of the participating programs. It has also increased participation by those organizations closest to the problems each program is intended to ameliorate.

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* Only 3.4 % of available funds were used in FY 1984 for projects ranked in the 50th percentile or lower.

H.D.S.

COORDINATED

DISCRETIONARY

PROGRAM

PROGRAM SUMMARY

- 3,000-6,000 Preapplications
- 500-600 Finalists
- 200-250 Grants
- $25 Million
- 9 Funding Authorities
- 12 to 15 Priority Areas
- 3/100 Chances of Funding

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FUNDING SOURCES

AUTHORITY	FY 84 FUNDS
Aging	$5.5
Developmental Dis.	$1.5
Native Americans	$0.7
Social Science Rs.	$2.0
Head Start	$2.5
Child Welfare	$5.0
Child Abuse	$7.0
Adoption Opportunity	$1.5
Runaway Youth	$3.8

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BENEFITS

A. Increased Efficiency

- 1980: 117 Person-Days/Grant
- 1983: 39 Person-Days/Grant

Saving = 73 Person-Years

B. Increased Competition

* Preparation Cost of Full Application	--	$16,000
* Preparation Cost of Preapplication	--	$ 2,000
Cost of Competing Reduced by	--	**83%**

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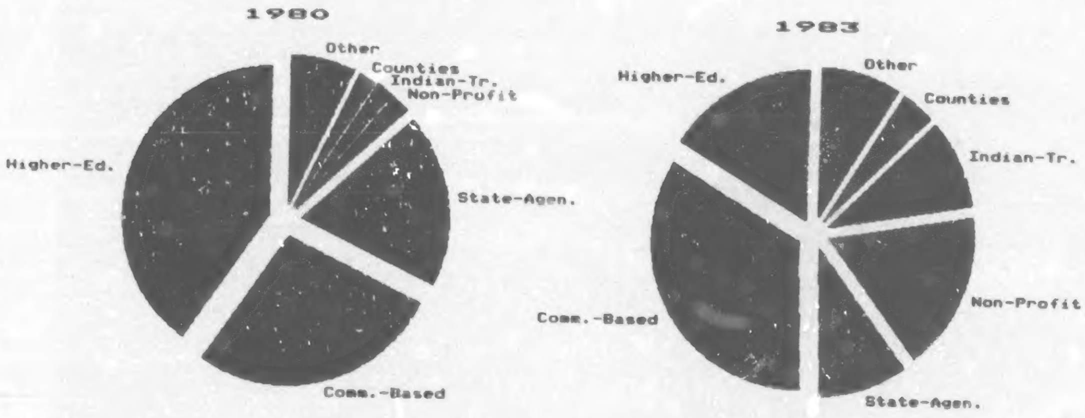
INCREASED GRANTEE DIVERSITY

Grantee Type By Proportion



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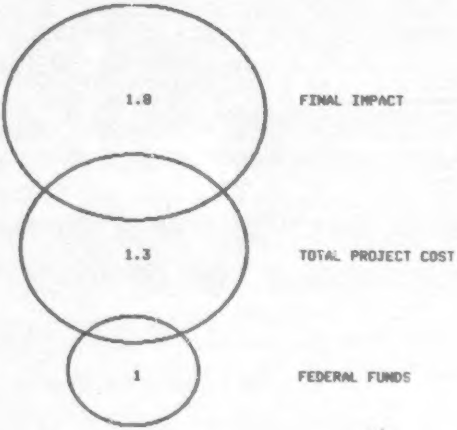
INCREASED IMPACT



FY 83 Federal Funds: $20,000,000 = Total Impact: $36,000,000

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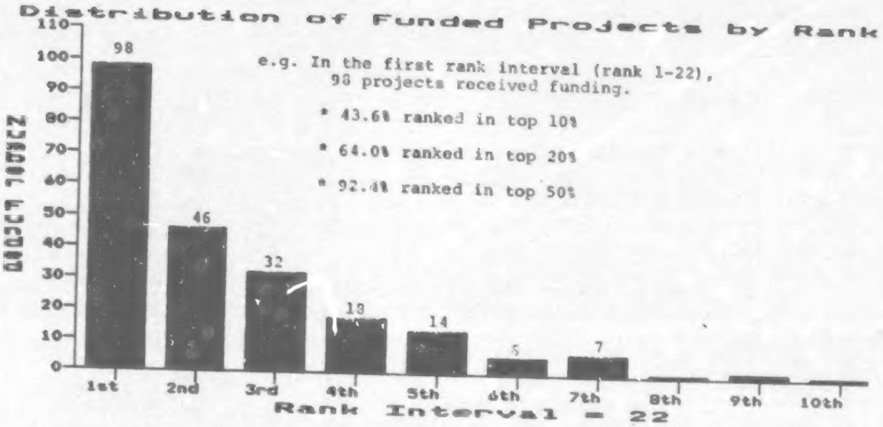

e.g. In the first rank interval (rank 1-22), 98 projects received funding.

- 43.6% ranked in top 10%
- 64.0% ranked in top 20%
- 92.4% ranked in top 50%

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Mr. TORRADO. Senator, can you see the charts clearly?

Senator PELL. Yes.

Mr. TORRADO. The first chart says "HDS Coordinated Discretionary Program," and I would like to emphasize the word "Coordinated" because, in fact, what we do is coordinate the grant-making activities of nine different specific discretionary authorities.

Let me give you a quick summary of the program. We receive about 3,000 to 6,000 applications every year. Specifically, this year we received 3,000. Of those, 500 to 600 applicants end up being finalists; they are selected to submit a full application. Of those, some 200 to 250 are selected as grantees.

Last year, we awarded about $25 million in grants, and those came from nine different funding authorities, about which I am going to say more a little bit later. Typically, there are 12 to 15 priority areas discussed in the announcement that goes out in early fall.

You can see from the numbers that there is a chance of being selected for funding of about 3 out of 100. This is particularly important to notice because when you focus on that figure, you realize that even if you define the best projects statistically as the top 10 percent, if you can only fund 3 out of every 100, it says that roughly 7 out of every 10 top projects cannot be funded because the funds are not available.

Let me give you very quickly an explanation of the process by which we award the grants. Before the process begins, there is a 2 to 4-month process by which all the program offices in HDS go through a planning process to develop those 15 priority areas.

Typically, it takes us about 30 different drafts before we have a document that we can publish, and the effort in going through all those drafts is an attempt to come up with a consensus as to what those priorities ought to be.

Every individual program has more than ample opportunity to put into those priority areas their own priorities. Let me give you a specific example of that. One of the priority areas has been gerontological training. The content of that priority area is designed and written by the Administration on Aging. Likewise, there are other priority areas where other programs in HDS have a similar input.

When the announcement is published, applicants have usually 60 days to prepare a preapplication, which is a 10-page document. These preapplications come in; they are reviewed by a group of field reviewers who are experts in the field.

The results of that field review are given to senior staff, and by that I mean the Assistant Secretary for Human Development Services, the Commissioner on Aging and the other commissioners, who discuss every single project and select those who are to be invited to submit a full application.

Finalists are given 35 days to come in with a full application and the process goes through the same cycle again. At the end, we have roughly 200 to 250 grants.

There are a number of benefits, and before I go into those let me list the nine different funding authorities that contribute to the program. Let me also point out that even though these nine different funding authorities contribute to the program or participate in the program, by no means do they put all their available funds into the coordinated discretionary program. The nine includes the Head Start Act Child Abuse Prevention and Treatment Act, Runaway and Homeless Youth Act, Developmental Disabilities Assistance and Bill of Rights Act, Older Americans Act, Native American Programs Act, Adoption Reform Act and sections 426 and 1110 of the Social Security Act.

For example, in the case of aging, while there was about $22 million available for discretionary programs, only $5.5 million was included in the coordinated program.

Now, there are a number of benefits that derive from this procedure. No. 1, there is increased efficiency. We took a look at some of the analysis that the Grace Commission did and some of the studies that have been performed in HDS, and we found that if we compared the way the grants were administered or were awarded in 1980 to the way they were being done under the coordinated discretionary program in 1983, in 1980 it took 117 person-days for every grant that was awarded. In 1983, that number has been reduced to 39 days, or a savings of 73 person-years. That is an increase in efficiency of roughly 300 percent—quite significant, I believe.

Second, there is increased competition. I mentioned that in order to compete, an applicant has to submit a 10-page preapplication. Well, if you look at the cost of preparing a full-blown application, which typically consists of about 50 to 60 pages, it will take about $16,000 to $20,000 of the resources of an applicant to put together that application.

By requesting only a preapplication, that cost to the applicant is reduced to about $2,000, and that is a savings of 83.3 percent to the applicant. Now, in practical terms, what this does is reduce the competitive advantage that big, experienced, well-funded organizations have over small, community-based organizations that might have good ideas to propose but do not have the resources to spend on submitting a full-blown application.

The third benefit that we derive from this is increased impact. When you consider both the fact that we require a match from the grantees and that we also are able to reduce costs by combining projects, the total impact that we get from every Federal dollar that we put in is about $1.80, and let me give you a specific example of that.

We have a project out in California that is trying to devise computer software for a variety of programs, including Head Start, including the elderly, including people with developmental disabilities.

If we had devised three sets of software independently, it would have cost us about $250,000 for each of those projects. Instead of that, we have one project that cost roughly $300,000 that generates the same software that is available for everybody at a significant saving.

When you consider that we award roughly $20 million to $25 million annually, the total impact of that $20 million is roughly $36 million, and that $16 million is not coming out of the Federal budget.

Now, I mentioned that there has been a decrease in the gap between the big organizations and small, community-based organizations in their ability to compete. If you take a look at the different types of organizations that have been funded throughout the years and you compare the years 1980 to 1983, you find that in 1980 State agencies, community-based agencies and universities—those three types of organizations got the lion's share of all the grants—roughly 90 percent.

If you take a look at 1983, you find that that distribution has become far more even and that instead of three types of organizations getting the lion's share, we have now six or seven types that have a significant share of the action.

Now, there have been a number of concerns expressed about the fact that in awarding the grants we do not follow the field review rankings exactly. In fact, if you look at the actual results and you compare the probability of being funded against the ranked percentile, you find that roughly 64 percent of all the projects that were funded actually ranked in the top 20 percent, and 92.4 percent of those funded ranked in the top 50.

Even more significantly, the 7.6 percent of grantees who were ranked in the bottom 50 percent were awarded only 3.5 percent of all the funds. You might very well ask why that is the case. Well, there are two reasons for it.

One is that we apply two sets of criteria. The first is project-specific and is explained in the Federal Register, and asks things such as is this project well designed, is this project needed, is the organization a good one. Those criteria are applied by field reviewers, who see only about 15 pre-applications each.

The other set of criteria, also explained in the Federal Register for applicants to see, includes things like geographic distribution, ethnic representation, urban-rural balance.

Of course, in order to apply those, you have to have somebody to do it that is taking a look at the totality of projects that are being submitted. That is done by senior staff.

If you run a correlation between the probability of being funded and the reviewer's ranking, you find that the correlation is about 75 percent, which is indeed very high. The other 25 percent is explained by applying those other criteria that I just explained.

Second, I want to give you a couple of examples of those projects that get funded in that bottom 50 percent, the 3.5 percent of funds that go to those low-ranked projects. In every instance, those projects come from minority organizations that have submitted a concept that is extremely intriguing and that has high promise and low cost. And yet the applicants were not very good at writing the pre-application. Let me give you a specific example.

We have one project that was funded to generate jobs for inner city residents out of a world's fair. Now, that is not a very traditional project, but it resulted in some specific, desirable outcomes.

We had another project in that category to provide income to Alaskan natives out of the commercial sale of their handicrafts that they do during the winter months.

So, as you can see, we have followed the reviewers' scores to a very high degree, and where there have been deviations, it has been for very good reasons. If you have any questions, I would be happy to answer them.

[Responses of Mr. Torrado to questions submitted by Senator Grassley follow:]

SUPPLEMENTAL QUESTIONS FOR MIGUEL TORRADO FROM SENATOR CHARLES GRASSLEY

QUESTION: I notice in a document which you provided for us that the Older Americans Act contributed about five and one-half million dollars to the Coordinated Discretionary Program in fiscal year 1984, and about six and one-half million dollars in fiscal year 1983. The total funding level for the Title IV program in fiscal year 1983 was about 22 million. I take it that the difference between what Title IV contributed to the coordinated program and the total funding for the program is accounted for primarily by continuation funding for various on-going projects?

ANSWER: o The total funding level in FY 83 for title IV of the Older Americans Act was $22,175,000. Grants made under the Older Americans Act through the Coordinated Discretionary Funds Program in 1983 totaled $8,358,354. The remaining funds were used for continuation of projects and new projects under specific initiatives within title IV of the Older Americans Act. The $22,175,000 were allocated in the following manner:

	Through the Coordinated Discretionary Program	Other Administration on Aging
New Starts	7,581,981	6,155,094 est.
Continuations	423,639	7,661,552 est.
Other *	352,734	

QUESTION: You noted in your written statement provided to the Subcommittee earlier that priority areas featured in the program announcement for the coordinated program are selected through a detailed planning process. Can you tell us a little more about that? Have you a documented record of planning meetings which you could make available for the Subcommittee? You mentioned that national organizations participated in this process? Which organizations participated?

ANSWER: o The planning process for the Coordinated Discretionary Funds Program begins nearly five months before the announcement is published in the Federal Register. The first step taken is for each program and staff office to develop issue papers outlining proposed priorities for the next year. An intensive working session is then held which includes each of the program offices and the Office of Program

* includes CDP/categorical supplemental grant awards, and categorical contract and administrative obligations

Development within the Office of Human Development Services. From the discussion at this meeting a preliminary draft announcement is developed. A number of planning meetings are held from this point on to refine the new priority areas and iron out problems. This process normally requires multiple revised drafts, each of which is commented upon in writing by each Program Commissioner. When final agreement is reached, the program announcement is signed by the ASHDS and all commissioners. A documented record of the planning meetings is not kept.

o Outside contributions from individuals and organizations are extensive and welcome. Each program office interacts on a regular basis with national organizations and other outside experts requesting their advice and guidance. The Office of Program Development contacted by mail over 200 organizations as well as 1500 national experts requesting their suggestions for research and development issues. The list of organizations and individuals will be provided if requested.

QUESTION: The priority areas listed in the program announcement are rather general and are also rather cross-cutting. Have you had any difficulty getting panels together on which appropriate skills and knowledge are represented?

ANSWER: o An extensive list of approximately 1500 reviewers who are experts in their field has been developed. Each field review is structured so that subject matter experts, generalists, practioners and community representatives are included. HDS has experienced no difficulty in obtaining suitable reviewers.

QUESTION: You mention, with respect both to pre-applications and final applications, that applications are reviewed first by peer review panels and then by senior staff. I know that the grants management office has rules which govern the administration of peer review panels. That is correct, is it not?

Does the grants management office oversee the second review by senior staff? Do you develop clear criteria for evaluation of applications in the second stage review so as to insure reliability of ratings? Are individual proposals read and rated by more than one senior staff person? Are applications scored by senior staff? Is this part of the process documented?

ANSWER:

- It is correct that the Office of Management Services, Division of Grants and Contracts Management has developed rules - based on Departmental regulations - which govern the administration of peer review panels. The entire field review process, both at the preapplication and full application stage is operated under these rules and under the supervision of the Grants and Contracts Office. Staff of that office often attend field review meetings. In addition, the director of the Office of Management Services is part of the Senior Staff and attends all decision meetings.

- Criteria are developed for both the preapplications and final applications and published in the *Federal Register* as part of the Coordinated Discretionary Funds Program announcement. Score sheets are printed for use by reviewers which reflect the criteria published in the *Federal Register*. Each application is reviewed and scored by the field reviewers only. The results of these reviews are the basis for all discussions by Senior Staff who make the final decisions. These Senior Staff decisions are part of the documentation. Strictly speaking however, applications are not *scored* by Senior Staff.

QUESTION: You mention that there is a grantee match expected from the grantee in this program. How big a match is required? What is accepted in the way of a match? Are hard dollars required, or are in-kind contributions accepted? Is there any indication that this match has discouraged applications?

ANSWER:

- Grantee share of the project is at least 25% of the total cost, which must come from a source other than the Federal government. Exceptions are projects funded under the Native Americans Act authority, where the grantee match must be 20% of the total cost of the proposed project; and applicants who already have an institutional cost sharing agreement with HHS. This match may be in the form of grantee-incurred costs or third party in-kind contributions. These requirements are published in the *Federal Register* as part of the Coordinated Discretionary Funds Program Announcement. We have no indication that this match has discouraged applications.

QUESTION: You mention in your statement that the ten page pre-application allows organizations with weak proposal writing skills, such as smaller community organizations or Indian tribes, to compete with more sophisticated organizations. Now, I know very well that there is no necessary relationship between proposal - writing skills and the skills necessary to carry out a project in a competent way. But if an organization cannot produce a good proposal, which after all, is the only thing on which you can base a judgement as a organizational capacity, how can you know whether it can carry out a project?

And if they can't write a proposal, how are they going to write a final report which is useful? The final report, after all, is the only way anyone other than the grantee is going to know anything about the project and whether it did anything of use to anybody else.

ANSWER:

- o The purpose of the 10-page pre-application is to see if an applicant has a worthwhile and innovative idea. These ideas often come from grass roots organizations that are not very sophisticated proposal writers. This does not necessarily mean, however, that they cannot write a final report. Through effective project monitoring, HDS project officers can provide a grantee with the technical assistance necessary to develop a high quality final report.
- o It should also be noted that in our experience, a highly polished proposal is not necessarily a guaranty of grantee performance or the ability to submit a suitable final report.

QUESTION: You mention in your statement that final decisions are made only after consultation among senior staff, rather than by one program official in isolation.

Let me first ask: would the terms "senior staff" and "one program official in isolation" include the Commissioner on Aging?

The Older Americans Act says in Section 411 that the Commissioner may make grants. From the point of view of the Older Americans Act, or perhaps more precisely, from the point of view of the Subcommittee which authorizes the Older Americans Act, why should we be concerned with OHDS-wide criteria?

ANSWER: o The purpose of the Coordinated Discretionary Program is not to apply "OHDS - wide criteria" but to insure that all populations covered by each of the participating programs receive the maximum possible benefit from available funds. This can best be achieved by coordinating the grant making activity of the various discretionary programs affecting HDS populations, and indeed the results of the Coordinated Discretionary Program demonstrate this. Elderly populations have received $1.80 of benefits for every $1.00 of Title IV funds awarded through the Coordinated Discretionary Program based on the required matching funds and the additional benefits leveraged from recombining of funds. This has been done without curtailing in any way the authority of the Commissioner on Aging. All final decisions on award of Older American Act funds are made by the Commissioner. She is a part of the HDS Senior Staff and discusses projects with them, but the decisions remain with the Commissioner.

Senator PELL. Well, thank you very much. I would defer to our acting chairman and the President pro tem of the Senate. We are very honored that Senator Thurmond could be with us.

Senator THURMOND. Thank you very much. I am a new member of this subcommittee and, in fact, the full Labor Committee. I used to be on this committee back in 1957 when President John Kennedy was then Senator Kennedy and was the ranking member. In fact, he was the chairman at that time, I believe.

At any rate, I have got to go to another committee for an emergency meeting, but I just wanted to ask one question. Dr. Tolliver, is this administration taking reasonable steps to protect our senior citizens as best it can, in your opinion?

Dr. TOLLIVER. In my opinion, I would say that it is, Senator. We have been able, through the title III program, which provides for supportive and nutrition services, to increase the services that are available.

We have been able to train significant numbers of persons in gerontology, and to provide in-service training to people who are working within the network. The fact that we have been able to build a national data base on aging should help us in the future as we plan for the increasing number of older people that we will have in our country.

Senator THURMOND. I think sometimes the public may forget the service our senior citizens have rendered. They are the ones who brought this Nation to what it is today, and this Nation has made more progress than any nation in all of history has made.

Our senior citizens have reared families. They have gone forward in technology and they have gone forward in advancements in every way in the world, and I remember when I was a young teacher starting out in the 1920's when radio was just coming in.

Since then, of course, we have television and pictures coming through there. We have put a man on the moon and now we are in space programs. We are doing so much, and I think frequently the public overlooks that these things were brought about chiefly by people who are now the senior citizens.

So, anything reasonable and fair we can do for our senior citizens, I think we ought to try to do it.

Dr. TOLLIVER. Well, I am sure that older people would appreciate that kind of support.

Senator THURMOND. I just want to commend you people who are working on this program—section IV, I believe it is.

Dr. TOLLIVER. Yes.

Senator THURMOND. And I hope you keep up your good work.

Dr. TOLLIVER. Thank you, Senator.

Senator THURMOND. Mr Chairman, I have another meeting. I have to go. It is a pleasure to be with you.

Senator PELL. Thank you very much, Senator Thurmond. I think it might be of some interest as we look around the room to realize that the only two senior citizens in this whole room are the two Senators who are hearing the testimony. [Laughter.]

Dr. TOLLIVER. Still being resourceful, too. [Laughter.]

Senator THURMOND. And we feel mighty good and hope to continue rendering good service.

Senator PELL. Keep up your good work.

Dr. TOLLIVER. Thank you, Senator.

Senator PELL. I think that will be all with this panel. We will ask you, if you would, to reply to some questions that will be submitted in writing for the record. We thank you, Commissioner Tolliver and Mr. Torrado, for your presentation.

Dr. TOLLIVER. Thank you, Mr. Chairman.

Senator PELL. Now, we move on to the next panel. As a matter of courtesy and with the approval of the chairman, Senator Grassley, I would like to call on the panel that consists of Ms. Margaret Barnes, director of the Gerontology Information and Training Center, Hampton Institute, and Ms. Joyce Hall, mental health coordinator and coordinator of Elder Abuse Program, Rhode Island Department of Elder Affairs, if they could come forward at this time.

I would explain to the other panel that the reason I reversed the order is Ms. Hall comes from Rhode Island and I wanted to hear her testimony and personally welcome her here. I have to leave in a short time.

I would particularly like to welcome her to the subcommittee this morning. She comes from my own State where she has an excellent reputation, and the elderly abuse program that she has directed under a title IV demonstration grant has been most successful.

Elderly abuse, like child abuse, is all too often a subject that goes unaddressed in our society unless a courageous person or group is willing to cause some trouble to force the rest of us to face the issue, and the elderly abuse program in our State has helped to have that effect.

Before the program began in 1981, there was little public awareness of elderly abuse and no public attention devoted to responding to it. Now, one grant and 3 years later, Rhode Island has a State law that requires any person to report known elderly abuse, and requires the elderly affairs department to investigate any allegations.

Senior citizens and the general public, because of the department's efforts, now know that abuse does exist and know where to turn for help. Many families with problems have been counseled and helped, and lives have been saved. In my opinion, our experience with this grant is just one example of the tremendous value that title IV adds to the Older Americans Act.

I look forward to hearing the testimony on this subject, and now would ask, I guess, Ms. Barnes if she would lead off here. Ms Barnes is the director of the Gerontology Information and Training Center, Hampton Institute.

As you know, we ask that the witnesses' presentations be limited to 5 minutes, and I find in my own case I can absorb much better if it is done extemporaneously. Thank you.

STATEMENT OF MARGARET N. BARNES, DIRECTOR OF GERONTOLOGY, HAMPTON INSTITUTE, HAMPTON, VA; AND JOYCE HALL, MENTAL HEALTH COORDINATOR, AND COORDINATOR, ELDER ABUSE PROGRAM, RHODE ISLAND DEPARTMENT OF ELDER AFFAIRS

Ms. **Barnes**. Thank you. Mr. Chairman, other members of the Senate Subcommittee on Aging, we thank you for the opportunity to appear before you to comment on the Administration on Aging and the merits of title IV of the Older Americans Act.

Your earnest and thoughtful consideration of appropriations for this title——

Senator **Pell**. Could you pull the mike a little closer still? Thank you.

Ms. **Barnes**. Your earnest and thoughtful consideration of appropriations for this title and those who administer it should subsume the impact of title IV on the identification of the need, the designs and the implementation strategies for policies and programs that have implications for all Americans, including more than 25 million older Americans.

The activities currently funded under this title are imperative to aging in America. It is through relevant research that we learn more about the aging process, its ramifications, its treatment, and the consequences of ignoring or neglecting it.

Is through the teaching of gerontology that we prepare individuals not only to assist others in aging, but to understand and cope with their own aging processes. Discretionary dollars have provided support for innovative and creative ways of addressing aging-related issues. If successful aging in America is to be realized not only by one older American or by the current 25 million older Americans, but by all Americans, none of the title IV activities are dispensable.

Directly related to my testimony is the need for more black gerontologists and their potential impact on the development of aging-related data and in the delivery of services to minority elderly.

While the need for more minority gerontologists is reiterated in the literature and in testimonies such as this, the need is more evident in the realities of aging in America. The preponderance of literature that does not tap the minority aged, the declining participation of minority elderly in Older Americans Act-funded programs, and the scarcity of minorities among administrators and policymakers in the aging network are testimonies of a different sort to the need for more minority gerontologists.

In the wake of calls for more black gerontologists to perform as researchers, instructors, administrators, and service deliverers, I ask who can respond? There are remaining today about 102 predominantly black, historically black colleges and universities in this country. I say "about" because current events tell me that many black colleges and universities are struggling for survival.

While representing only 3 percent of all the institutions of higher learning in the United States, these black colleges and universities enroll more than 20 percent of all black students in college today. The large pool of black students on these campuses identifies these historically black colleges and universities as prime sources for black gerontologists.

In Executive Order 12320, dated September 15, 1982, the President of the United States, Ronald Reagan, called upon Federal agencies to work toward increasing the participation of historically black colleges and universities in federally sponsored programs.

The current Commissioner on Aging, Dr. Lennie-Marie Tolliver, and her staff at the Administration on Aging responded to the Executive order. Part of the response from the Administration on Aging, Department of Health and Human Services, was the funding of a historical black colleges and universities consortium through the gerontology information and training center at Hampton Institute.

The staff of the gerontology program at Hampton Institute was among those from six historically black colleges and universities attempting to cooperatively address some of the issues faced by the gerontology programs at their respective institutions.

Dwindling resources, lack of adequate faculty trained in gerontology, insufficient dollars for relevant research, survival threatened by budget cuts, barriers to networking with State and local agencies on aging, the need for doctoral and postdoctoral level gerontology training for their current faculty, and the need for more information and expertise sharing among historically black colleges and universities were but a few of the issues noted.

The roster of issues commonly identified by each of the gerontology directors from the historically black colleges and universities underscored the appropriateness of collaborative action.

The Administration on Aging grant received in September 1983 met a dire need. After almost 9 months of working toward organizing and recruiting other colleges and universities, most of the gerontology program budgets had been exhausted of means to support the group's efforts.

With grant support from the Administration on Aging and additional support from its region III office, the consortium has grown and presently includes 21 institutions and more than 30 members.

The Federal dollars from title IV have supported the development of two conference meetings, a directory of gerontology programs at historically black colleges and universities, and the dissemination of a monthly newsletter.

The initial conference meeting held in September 1983 resulted in the drafting of bylaws and the incorporation of the Association for Gerontology and Human Development in historically black colleges and universities, commonly known as AGHD.

The second conference meeting, scheduled for April 25 through 27 in Philadelphia, will focus on capacity building for gerontological research, training, and service in historically black colleges and universities.

The directory and the newsletter have assisted AGHD members in sharing information, resources, and expertise. In the appendix you may find a sample listing from the directory that details the courses and services offered, expertise areas, contact persons, and cooperative efforts desired by individual institutions. Also included in the appendix is a list of those historically black colleges and universities affiliated with AGHD, and a sample newsletter.

In conclusion, I request your consideration of the efforts of historically black colleges and universities to meet the challenges of gerontology in higher education that are uniquely theirs; to produce black gerontologists; to generate relevant minority aging data; to maximize the utilization of their resources and their skills; and to contribute to the field of gerontology during these austere times.

Title IV of the Older Americans Act, today more than ever, can play an integral role in gerontological efforts at historically black colleges and universities. My testimony is in support of not a sustained appropriation for title IV of the Older Americans Act, but a reversal of past reduction trends.

The reduction in appropriations from $54.3 million in 1980 to a little over $22 million in 1982, and maintaining that appropriation level through 1984, was drastic. Historically black colleges and universities are experiencing the impact of that reduction America as a whole suffers. Training, research, and demonstration projects are basic; they establish the foundation for successful aging in America.

Mr. Chairman, this concludes my prepared remarks.

[Responses of Ms. Barnes to questions submitted by Senator Grassley follow:]

QUESTIONS FOR MARGARET BARNES FROM SENATOR CHARLES E. GRASSLEY

1. **WHAT HAVE YOU DONE TO SEE THAT THE RESULTS OF YOUR PROJECT ARE APPROPRIATELY DISSEMINATED?**

The dissemination efforts for the Title IV-funded projects are varied. In addition to utilizing the gerontology program's two newsletters (nine issues annually, distributed nationally), the project utilizes other media, conference presentations, exhibits, project printed and audio-visual products, and dissemination meetings to share its Title IV activities. As the award also purchased some library holdings, an off-campus loan system (that records users from across the nation) was established during the grant period. Board members are also useful in the dissemination plan.

Media activities have included numerous newspaper articles and talk shows. Conference presentations have been local, regional, and national and include workshops, training sessions and seminars. Information about the projects have also been exhibited locally, regionally and nationally. Our printed and audio-visual products include modules, manuals, slide presentations, directories, and video-cassettes. A dissemination meeting, recently held, provided representatives from national organizations with extensive information and technical assistance on developing and implementing intergenerational activities. Two program boards, one local and the other national, helped to spread information about the projects.

As our program has a gerontology information and training center base, our primary goal is to develop, acquire, and disseminate information. Hence, we are very successful in dissemination efforts and are proud of our track record.

2. **WOULD IT BE CORRECT TO INCLUDE FROM YOUR TESTIMONY THAT THE ADMINISTRATION ON AGING WAS HELPFUL DURING THE COURSE OF THE PROJECT? IS THERE ANYTHING MORE AOA COULD HAVE DONE TO BE HELPFUL?**

Yes, AoA has been and continues to be very helpful to the program's staff. Both the Washington and Philadelphia (Region III) offices have provided invaluable assistance to the staff in implementing the projects. Consultation and technical assistance, coupled with encouragement and physical presence have been received from both offices. We have been exceedingly pleased with the cooperation from AoA.

3. **DO YOU THINK THAT YOUR PROPOSAL WAS FAIRLY AND THOROUGHLY EVALUATED BY THE ADMINISTRATION ON AGING?**

Yes, we think our initial applications were fairly and thoroughly evaluated by the Administration on Aging.

4. **HAVE YOU HAD ANY INVOLVEMENT WITH THE LONG-TERM CARE IN PHILADELPHIA? IF SO, HAVE THEY BEEN HELPFUL?**

Yes, we have collaborated with the long-term care gerontology center in Philadelphia. In addition to sharing information, staff from the center presented a session on their activities during one of the project - sponsored events. The session was informative and useful.

Senator PELL. Thank you very much indeed. Now, we have Ms. Joyce Hall, who has done such a fine job in Rhode Island. And I must say as I think of this program in the Older Americans Act, it fills such a tremendous vacuum in the Nation when I think what it must have been like before we had the attention directed as we do now on the plight of our older citizens.

And our desire here is not merely the extension of their life, but also to increase the quality of their life and make sure that abuses do not occur; that they are able to lead a fuller life.

Here, I am also very struck by the fact that when you ask groups of older people would they rather be by themselves in an apartment or would they rather be in the hurly-burly of their family, very often they prefer to be in the hurly-burly of their family.

I think one of the things we ought to do is to do what we can to encourage families not to be the modular family we think of in America, but to have the various generations under the same roof, if it can possibly be done. I would be very interested in your reactions to that thought.

Now, I am glad to hear you, Ms. Hall, and I would add we will try to limit the witnesses to 5 minutes and statements will be put in the record as if read.

Ms. HALL. Thank you, Mr. Chairman and other distinguished guests, for asking me here today.

In 1981, the Rhode Island Department of Elderly Affairs was one of only 3 States in America to receive a 3-year discretionary grant from the Department of Health and Human Services to study the growing national problem of domestic elderly abuse.

The grant was designed to develop parameters to investigate the prevalence of elderly abuse in Rhode Island; develop and implement appropriate methods of intervention; be responsible for the coordination of available services.

Specific tasks were to generate and create public awareness of the elderly abuse program to the elderly, their families, and social service providers; to investigate every report or incident of suspected abuse by conducting indepth home assessments; to provide counseling to the victim and their alleged perpetrators.

We developed individual case plans for remedy and service. Some services not readily available were developed, such as emergency shelter. We developed and utilized research instruments; provided ongoing training of elderly abuse staff and staff of the aging network and other agency and service providers.

Evaluation was regionally coordinated with the New York and Worcester programs through the University of Massachusetts. Several cluster meetings were held with the University of Massachusetts, AOA, and the three States mentioned.

All three programs were evaluated using the same terms, definitions, methodology, and reporting forms. It is our belief that this is the first scientific evaluation of a reasonable sample study. A copy of the report will be available very shortly and we would be pleased to submit that to you.

The Rhode Island abuse program became operational January 1981, and covered a period of 3 years with funding that ended December 31, 1983.

For a little history, from the inception a mental health planner within the department of elderly affairs was assigned the task of coordinating mental health services. Numerous situations surfaced regarding people who fell through the cracks and which could be conceptualized as abuse of one type or another; for example, physical, psychological, neglect, abandonment, and exploitation.

Most of these abuse cases seemed to arise within family households rather than within institutions. Requests made to police departments and the Attorney General's office revealed no available data on incidences of elderly abuse.

Although many agencies and individuals admitted it was happening in the community, no one was able to give any pertinent data on its prevalence. The dilemma of elderly abuse was also a major focus of a statewide mental health conference, convened jointly by the department of elderly affairs and mental health, retardation and hospitals. This conference was held in April 1980, and many major departments and agencies that impact the lives of older Rhode Islanders attended.

The information and referral unit within the department of elderly affairs assisted the elderly abuse unit by documenting many cases they considered to be elderly abuse; for example, psychological, frequent verbal threats, refusal of necessary services, financial exploitation, removal of money or assets from the control of the abused by children or family members.

Many of these reports did not come from the person being victimized, but from other family members, relatives, friends, or neighbors. When the victim did call, often they would not reveal their name nor address because they felt ashamed, guilty, or stigmatized.

Consequently, there was no established mechanism in place that could provide this service; hence, the need for a model program. In 1980, a protective services bill was introduced in the Rhode Island General Assembly, but the legislation did not pass. In 1981, the department of elderly affairs sponsored a mandatory reporting bill on elderly abuse, and this bill was passed. This act mandated the reporting of elderly abuse and provided that a fine be levied against persons knowing of abuse and not reporting it.

Also, an obstruction of provision of services clause addressed to caretakers, family members, and/or agencies who refused or stopped services needed by the elderly person was defined in the law as abuse. The law was amended in June 1982 by adding an immunity from liability clause.

The timeliness of this bill's passage, which coincided with the implementation of the elderly abuse grant, greatly enhanced the opportunity of reaching the goals included in the grant proposal.

The goals included the following: determining prevalence; types of abuse; appropriateness of intervention; treatment services; and resources that led to more timely detection and intervention of elderly abuse.

To further the goals mentioned above, seven key councils were created throughout the State comprised of multidisciplinary agencies and organizations. Centralization of comprehensive service providers has maximized the coordination of multidimensional resources needed to address the issue of elderly abuse and to do so more efficiently.

In Providence, the key council consists of 52 public, private and local agencies. Its composition includes six major departments: social and rehabilitative services; department of elderly affairs; mental health, retardation and hospitals; department of health; department of community affairs; and the attorney general's office; police; fire; housing code enforcement; hospitals; lawyers; judge; psychiatrists; internists; senior center personnel; legislature; nursing home representatives, and so forth.

Meetings are held monthly and the council also functions as a viable mechanism to assist in case planning for many elderly who otherwise would fall through the cracks of traditional social service agencies.

The program is available to any person 60 and over. A service delivery system was developed utilizing a case management mode. A social worker was hired with grant funds. This staff person provided the initial home assessment, remedial action, case planning, and coordination of appropriate services. The social worker was also responsible for monitoring and following up each client.

Upon implementation of the case plan, the case management function was then transferred to the appropriate agency for ongoing case management and service. Due to the program being statewide and project funds only able to support one social worker, this transfer was effected as quickly as possible.

Most cases necessitated the social worker to make a home visit twice. However, other cases required more visits. The department of elderly affairs retained the monitoring and followup responsibility until the problem was resolved. A case was never inactivated or closed until 3 months after the problem had been resolved and followed up.

Advocacy for the elderly person was essential to bring about satisfactory resolution to the problem, both with the perpetrator and service providers. The primary consideration of the department was a policy decision to never leave the situation worse than when we first became aware of the alleged abuse. Consequently, the department involved the perpetrator and/or service provider at the very beginning unless the abused person requested that we not do so.

The high visibility and credibility of the State agency on aging, coupled with the knowledge that our services are not entitlement programs, nor is the department a law enforcement agency, contributed to the significant success of the program.

The comingling of Older Americans Act title IV discretionary programs within the office of human development funds makes it somewhat difficult to discern from our perspective when funds appropriated for specific populations, especially the elderly, are, in fact, actually being used for that population group.

As an agency whose primary concern is to serve the elderly, in concert with human health services regulations and with direction from AOA, we urge you to allow the Office of Human Development Services to maintain title IV separate and apart from the office of human development services coordinated discretionary funds program.

Aging agencies should have appropriated funds for the purpose of developing proposals that would benefit the older population rather than to bury these funds into a community pool of resources which may not be discernible.

From its inception, region I office staff was continually involved with the development and implementation of Rhode Island's abuse project. It was AOA's idea to expand the evaluation component in the Massachusetts elderly abuse project to include Rhode Island, Worcester, and New York elderly abuse projects.

The regional office also proposed and obtained clearance for corroboration of the three projects and the University of Massachusetts in the preparation and development of one "how to do it" manual, drawing on the experience, data and evaluation results generated by all three projects.

Rhode Island greatly benefited from onsite assistance with regional staff familiar with the discretionary grant program. Other State programs were also involved with our dissemination efforts, including training, conferences, and workshops in individual States and throughout the region.

I propose to make the following recommendations that deal with elderly abuse which must be viewed as an issue separate and different from protective services. We need both these programs, but my recommendations focus on elderly abuse.

The reauthorization of the Older Americans Act should include a statutory provision and authorization for funds mandating that every State be required to implement an elderly abuse program.

I urge this body to consider a clear and definitive distinction between elderly abuse and protective services. These two services are not the same. In making this distinction, there is the need to consider one of the biggest problems—loss of rights—under protective services legislation.

Protective service is usually designed for incompetent people. Elderly abuse most often is involved with competent people who do not need, nor do they desire, an agency to make decisions for them, but they do need laws which provide them with protection and service. They do need guardians ad litem; they need champions, advocates.

We endorse and urge congressional passage of House bill H.R. 1904, already passed in the House in 1984. This bill authorizes $65 million over the next 3 years for spouse and elder abuse.

I thank the committee for allowing me the opportunity to present this testimony on behalf of the Rhode Island State Department of Elderly Affairs regarding elderly abuse. Thank you.

[Responses of Ms. Hall to questions submitted by Senator Grassley follow:]

QUESTIONS FOR JOYCE HALL FROM SENATOR CHARLES GRASSLEY

ANSWERS:

1. Are people involved in these incidents - either those who are abused of those who do the abusing - willing to accept intervention by a social service agency?

   ANSWER:

   Under RI law the only person who can refuse to allow us entry is the elderly client. If another family member refuses us, we are mandated to notify the police to request that they go in with us or for us. We have only had to resort to this method three times during the program.

   There were 12 individuals, all clients, who refused to accept our intervention after our investigation. We address this by continuing to make contact with this person by phone or home visits to monitor and follow up on the problem. Another alternative used is to bring this type of situation before members of the Key Council in that area in a case conference to determine if the person is receiving some type of service or resource through one of the agencies. In this way we can monitor the situation through their contact with the person. If we feel that a life threatening situation may arise in the future, we contact the local police in that area and ask them to pay particular attention to any calls they may receive from this household. We strive to coordinate our efforts through use of the person's doctor, health center, church, etc.

2. Have you been able to find adequate temporary shelter for victims of abuse?

   ANSWER:

   Contrary to early studies done on the need for temporary shelter, our project has only encountered two situations where the elderly person required temporary shelter. We had anticipated the need for this type of service and had appropriated money out of our grant to address this problem. The plain fact is that the elderly do not want to leave their place of abode. Most times it is the elderly victim who owns or rents the home.

   Early on in the Model Project, the Department of Elderly Affairs utilized a student from Brown University who made a survey statewide of available temporary shelters that could be accessed by older abused persons. The results were dismal. DEA requested woman's shelters, nursing homes, hospitals, etc. to meet to discuss this gap in service. Shelters for battered women were willing to help, but their facilities were not easily accessible or appropriate for older persons. Nursing homes could not make space available unless the space was purchased on a continuous basis. State armories were cooperative, but could not provide this resource without assurance of available staff. Hospitals indicated it was not very appropriate to utilize their facility to provide shelter. Out of this effort, a subcommittee was formed by DEA, Providence Police and Bannister House Nursing Home. A formal written agreement was secured after many hours of meetings and trade off. This agreement is still in existence and as yet the only one available for use by our clients.

In late 1983, the RI Department of Social and Rehabilitative Services received Federal Funding for temporary shelters in Rhode Island, but this effort was geared more toward the young, chronic unemployed, who had lost their jobs and/or housing due to the depressed economics of the times. Consequently the elderly were once again "lost in the shuffle".

In one of the above situations, the client was not able to return to her room and was place in a nursing home. In the other instance, the client was provided with emergency shelter at a Women's center for the battered. She did return home with her spouse and is being monitored.

3. This Subcommittee is interested in how well the results of Title IV projects are disseminated.

What have you done to see that results of your project are appropriately distributed?

ANSWER:

Requests for information of this project have been disseminated to several states, through lectures at colleges, senior centers, church groups, agencies (state and local) both in state and out. Our Congressional delegates are sent copies of each year's proposal. We have sponsored and participated in statewide forums, seminars, and conferences.

The final report of our three year project will be submitted to the Governor, state legislature, Congressional delegation, state and local governments and agencies. We have also received requests for the final report from Canada, Georgia, Missouri, Bronx, New York, Maine, Illinois, Ohio, Pomona, NY, Ann Arbor, Michigan, Arkansas, Wisconsin, Alaska, to name a few.

Further, the "How to Manual" being developed by the University of Massachusetts will be disseminated nationwide when completed.

4. Would it be correct to conclude from your testimony that the Administration on Aging was helpful during the course of the project? Is there anything more AoA could have done to be helpful?

ANSWER:

The AoA was very instrumental in the success of our project. They were always approachable and available to provide us with their technical assistance and support. They continuously sought ways to improve our communication and coordination with our sister projects in New York and Worcester.

It was through their intervention that the three projects corroborated efforts with University of Massachusetts to produce a "How to Manual". They advocated for and facilitated the inclusion of elderly abuse at regional meetings, seminars, and conferences. Our success could not have been possible without their help.

5. To what extent is abuse of older people a continuation of behavior or relationships which existed prior to a person's becoming aged?

ANSWER:

Conclusions are not yet definitive enough to project a conclusive answer. There are other cases where this clearly is not so. Some older person's attitude and behavior is said by family members to have changed (often negatively) in their later years. Some of the problems are due to stress and circumstances beyond the family's power to control, etc. ie; loss of financial resources, loss of home, sickness, death, and long term illnesses. This is definitely one area that needs far more research and study before conclusions can be made.

6. Did the Administration on Aging help in coordinating the three projects and the work of the evaluation team at the University of Massachusetts?

ANSWER:

Yes. Please see #4. AoA should also be commended for recognizing the value of coordinating the three Model Projects with the University of Massachusetts, for finding the funds to develop the manual and arranging the cluster meetings which afforded us to share information, frustrations, and outcomes of our efforts.

7. Do you think that your proposal was fairly and thoroughly evaluated by the AoA. I refer to your initial application.

ANSWER:

Yes. AoA was thoroughly involved and helpful to RI in preparing and submitting our project proposal. There were many phone calls, on site visits, and consultations with staff to refine content issue and fine tune the application procedure.

8. Have you had any involvement with the long-term care gerontology center in Rhode Island? If so, have they been helpful?

ANSWER:

Yes. The Project Director is a member of the Minority Relations Sub-committee of the long-term gerontology center. In the area specifically related to abuse - we requested a student to work with us on this project, but the center was unable to respond to our request.

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Senator PELL. Thank you very much indeed, Ms. Hall.

Ms. Barnes, one question: What is your definition of a "gerontologist?"

Ms. BARNES. It is a person trained in the study of——

Senator PELL. Could you pull the microphone close to your mouth?

Ms. BARNES. It is "a person trained in the study of aging processes."

Senator PELL. Is that an A.B. or is it an M.A.?

Ms. BARNES. At Hampton Institute, we consider our trained gerontologists at the undergraduate level. I would think at some of the other historically black colleges, it would be at the master's level. Some of our historically black colleges do not have bachelor's or master's level programs in gerontology, but they do offer course work.

Senator PELL. But a gerontologist is a person who is particularly trained and educated in the problems of the aging?

Ms. BARNES. Senator Pell, you are addressing an issue that the field of gerontology has been discussing for the last 12 years: whether or not aging or gerontology is a study or a field.

My personal opinion would be that a gerontologist is someone with specialized training in aging and the aging process. I will speak for Hampton and not for the other historically black colleges and universities at this time, but I think the development of the curricula on our campus will indicate that our opinion of a gerontologist would be that person who has a concentration in aging or gerontology-related course work.

We do not offer a degree, a bachelor's degree in gerontology. We offer concentrations through human ecology and through physical education and through the department of management.

Senator PELL. Is there any institution of higher learning that offers a degree in gerontology?

Ms. BARNES. Oh, yes. There is master's and bachelor's level course work offered at historically black colleges and universities; we do not. We offer a certificate program for a specialist in aging, which is a very common practice.

Our philosophy at Hampton Institute is to couple that gerontological training with some other discipline to better prepare the person for work in the field.

Senator PELL. Thank you very much.

Ms. BARNES. You are welcome.

Senator PELL. Ms. Hall, how many years have you been with the department of aging in Rhode Island?

Ms. HALL. Twelve years now.

Senator PELL. Did you ever receive any reports before 1981 with regard to elderly abuse?

Ms. HALL. We never received any reports, but what I saw was people who were coming to the department had problems that certainly could be defined as elderly abuse.

Senator PELL. And approximately how many cases of documented abuse have been reported over the program's life so far?

Ms. HALL. We have full documentation on 533 cases in Rhode Island, and we have a population of about 177,000 older people, 60 and over. Now, when I say documented, that is not the number of calls. There were many more calls, but these were 533 cases that have been investigated and found as abuse.

Senator PELL. What procedures would you follow? Would you, for instance, go to court on some of these, or were you able to work them out by conciliatory proceedings?

Ms. HALL. Most times, we did not need to g[illegible] court. We recognized right away that, as you say, many older [illegible]ople do not want to leave their homes, nor leave their families; they would like the abuse to stop.

So, what we did from the very beginning was to try to work with the family member. We are not a police agency, as I said, and we do not go in accusing or blaming anyone in the household. We go in offering services, trying to uncover what the problem is and trying to alleviate that problem.

There have been some cases that have had to go to court; there have been a few perpetrators that have been incarcerated. We have had to take some older people out of the home; we have also had to take some perpetrators out of the home.

But for the main part we have been able to deal with the family, helping them to find other ways of coping with older people.

Senator PELL. Now, the funding for your grant has come to an end; has it not?

Ms. HALL. Yes, it has.

Senator PELL. What has been the procedure you have followed since that time?

Ms. HALL. Well, we began well over a year before funding ran out with trying to look at alternative plans. What we began doing almost from the beginning of the program was to train our aging staff and other agency staff, to be able to recognize and to be able to deal with elderly abuse.

So, now after funding has run out and we have lost our one social worker, what we are doing is delegating the responsibility for investigating cases to the members of the aging committee. I must say this is not, I guess, the best of all systems, but it is the only one we have available to us at this time, and they have received training.

Senator PELL. Why do you believe that the Older Americans Act should require elderly abuse services? If it is not there, there will be more cases of abuse?

Ms. HALL. No. What I see is that I think that elderly abuse probably has been here for some time; I do not think that it is a new problem. But what I do see is that until someone recognizes that and kind of brings it to the fore, almost as we saw with child abuse and also with the recognition of alcohol services, often nothing is done about it.

Often, many of the people that we serve in our program are known to other agencies. It is just that the abuse aspect of the case has never before been identified or recognized as such.

Senator PELL. I thank you very much indeed. I defer now to our chairman, who has returned, and ask to be excused to go to another committee.

[Senator Grassley resumed the chair.]

Senator GRASSLEY. Yes, and thank you very much; you were very helpful. We still did not get all the taxes raised that we were planning on.

While I am catching my breath, could you take your time now, Senator?

Senator METZENBAUM. Certainly. As a matter of fact, I came over because I am very much supportive of title IV of this act. For almost two decades, this legislation has helped improve the lives and health of our Nation's elderly.

I also want to say that I am particularly pleased that the chairman intends to include in this legislation the package of legislation that I had introduced having to do with Alzheimer's disease, and I think the next witness is going to speak to that subject. But I am going to have to excuse myself because of two other committee hearings.

But I want to say that I do not know of any subject that has disturbed me more and has been more frustrating than the challenge that people face when a member of their family has Alzheimer's.

As the chairman knows, with his assistance last time, we allocated $3.5 million to establish research centers on Alzheimer's disease, but we have to do more and my package would have to do with responsibility to the veterans; it would have to do with the tax aspects of deductability of nonmedical deductions; and it would also have to do with including Alzheimer's in as part of the title IV program generally.

With your permission, Mr. Chairman, rather than hold up the hearing, I would appreciate my entire statement being included in the record as if orally delivered.

Senator GRASSLEY. It will be.

PREPARED STATEMENT OF SENATOR HOWARD METZENBAUM

Senator METZENBAUM. Thank you, Mr. Chairman. I am here this morning to express my continued support for the Older Americans Act. For almost two decades this piece of legislation has helped to improve the lives and health of our Nation's elderly.

I am also here to call attention to a devastating disease affecting millions of Americans each year—Alzheimer's disease. Alzheimer's disease, as most of us now know, is a neurological disorder which at first seems to be nothing more than occasional forgetfulness. That slight loss of memory will progressively worsen until its victims are intellectually and physically disabled and totally unable to care for themselves. At this time, we don't know what causes it and we can offer no cure for it.

This subcommittee recently held hearings on Alzheimer's disease and therefore I will not recount the shocking statistics on this illness and its potential in the near future to reach epidemic proportions. We have witnesses before us today whom I'm sure will testify to those facts.

During the last session of Congress, I introduced an amendment to the Labor, Health and Human Services appropriations bill which allocated $3.3 million to establish research centers on Alzheimer's disease. Funding for research is, of course, critical to our effort to defeat Alzheimer's.

However, it has become apparent that for every victim Alzheimer's claims, many more friends and family members begin a long period of suffering. An Alzheimer's patient can live from 3 to 15 years after first being stricken and the financial commitment for caring for that victim can easily run into tens of thousands of dollars every year. By the time this illness claims the life of its victim, a family can be financially and emotionally bankrupt.

In an attempt to alleviate some of these hardships, I introduced in January, a legislative package which would lessen the financial demands of caring for a relative stricken by Alzheimer's disease. These bills were introduced on the House side by Congresswoman Snowe who has a longstanding commitment to this issue and who is with us today to testify.

One of these bills would amend title 4 of the Older Americans Act to give priority for student grants to those who will specialize in custodial or skilled care of Alzheimer's patients. Although 50 percent of the individuals admitted to nursing homes suffer from Alzheimer's, many facilities are unable to admit Alzheimer victims due to a chronic shortage of trained personnel.

This bill would encourage the training of such individuals.

Under this measure, an additional $5 million would be authorized to implement its provisions.

Congresswoman Snowe has informed me that her bill has been included in the House language of the Older Americans Act reauthorization. I would like to congratulate her on her fine work on the Select Committee on Aging. And I hope that through this committee we, too, can include the same measure in our version of the Older Americans Act.

Senator **Grassley**. I want to recognize publicly that you were working on this even before I became chairman of this subcommittee. I became involved after you did. You have established your position of leadership; I want to recognize that and say that I do not know whether at this point I can commit myself exactly to saying that we are going to include your program, but we are going to include the issue.

It may already be worked out at the staff level, but I have not reviewed that yet. But we surely are not going to ignore your proposal; I can assure you of that.

Senator **Metzenbaum**. The chairman has been fair and certainly concerned about this issue, and I am sure we will have no difficulty in working together on it.

Senator **Grassley**. Yes. In fact, I think we have already been doing that considerably at the staff level.

Senator **Metzenbaum**. That is correct. My absenting myself from the earlier part of your hearing and the balance of it is only because I do not have a three-faced personality that can be at three places at the same time.

Senator **Grassley**. Yes.

Senator **Metzenbaum**. I have two other hearings I must get to. Thank you.

Senator **Grassley**. Yes, I appreciate that. You have been very cooperative and I know that you will save time when we go into markup about 3 weeks from now so that we can all be together at that point.

Senator **Metzenbaum**. I will be there.

Senator **Grassley**. Thank you.

I hope you will pardon me because of my necessary absence to go to the Finance Committee. I will not ask you any questions. I may have some to submit to you in writing. I want to thank you for your kind attendance, and appreciate very much your working in ahead of the other panel out of order so that I could be here when my constituent is here. Thank you very much.

As I call the next panel, I have already introduced my expert on this subject, a constituent of mine, Mary Oliver, from Des Moines, IA. I would ask her to come up, and also we have Marylen Mann from St. Louis, MO, who would come at this time as well.

With regard to her introduction, I would like to say that Senator Eagleton is not able to be here. He wanted me to welcome you to the committee for him, and to tell you his regret, because of conflicts, of not being able to come. He was at our hearing last week, very attentive for a long period of time, and I appreciate that very much. We all have about three committee meetings going on simultaneously this morning.

You are director of the St. Louis OASIS program, and I appreciate your coming. You are going to tell us, I understand, about the very successful projects which have involved using department stores as settings for a variety of activities for older persons. This is an example of private sector initiative which the present administration has emphasized in title IV—initiatives which seem to promise greater involvement of the private sector in activities for more older Americans.

We also have Ms. Paula Lovas, who I would like to have come up at this time. She heads a project at the American Association of Retired Persons which is of great interest to this subcommittee.

AARP has undertaken to make available to interested parties the research and demonstration reports produced by the title IV program, and this project may be an answer to a problem which has plagued the title IV programs for many years, as I said in my opening statement.

Ms. Lovas is accompanied by a person we all know well, David Affeldt, from the legislative division of AARP. I guess you are going to make the opening statement, right?

Mr. **Affeldt**. That is correct.

Senator **Grassley**. You are our panel, so I would like to have Ms. Oliver go first and then Ms. Mann and then you, Mr. Affeldt.

Would you proceed?

STATEMENT OF MARY OLIVER, PRESIDENT, ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION OF DES MOINES, IA; MARYLEN MANN, DIRECTOR, OLDER ADULT SERVICES, UNIVERSITY OF MISSOURI AT ST. LOUIS, AND PROJECT DIRECTOR, OLDER ADULT SERVICES AND INFORMATION SYSTEM; AND PAULA LOVAS, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY DAVID AFFELDT, LEGISLATIVE DIVISION, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. Oliver. I wish to thank you for the opportunity to testify today. I am testifying as president of the Alzheimer's Disease and Related Disorders Association of Des Moines, IA

Our organization was formed in June 1981. At that time, there were three members. We now have nearly 300 paid members and our newsletter goes out to more than 2,000 people; 18 support groups have formed across the State which are informally associated with our organization.

We have a monthly educational and support meeting where families share their problems and learn about the disease. Recent topics discussed have been nursing home care, heredity factors, parent and adult child relationships, and management of the more difficult patient in the home.

During our family meetings, there is a respite group for the victims of the disease which is staffed by an art therapist and a recreational therapist, as well as one or two volunteers. The individuals who attend this group presently are in the early to middle stages of the disease and are able to enjoy the camaraderie of the group.

Each November during Alzheimer's Month, we have a workshop for families and professionals interested in Alzheimer's disease. Last November, more than 300 people attended the daytime meeting and we were forced to turn away another 75 or 80 because of space limitations. That evening, more than 250 people braved a rainstorm to hear Dr. Leopold Liss, a major researcher in the field of disorienting diseases.

We have a loosely organized telephone support network and an autopsy network to assist families in making early arrangements for autopsy so an exact diagnosis can be made. The hospital which supports our organization, Iowa Methodist Medical Center, also supports an Alzheimer's diagnostic clinic, staffed by a physician, psychologist, social worker and nurse.

In Iowa we are especially concerned about the care of the elderly, in that they comprise more than 13 percent of our population, elderly in this case being defined as age 65 or more.

We have several counties with 17 to 20 percent elderly, and five counties where the elderly population is more than 20 percent. Research has shown that the incidence of dementing illnesses increases with age, especially over age 75, which is our fastest growing population group.

We have more than 30,000 people in Iowa who are in nursing homes. Nearly half of these people are described as disoriented or confused. National research indicates that for every person institutionalized, there are two to three individuals in the community similarly disabled.

A rough estimate would indicate that we have 40,000 to 45,000 people in Iowa afflicted by Alzheimer's disease or a related disease. That means that 40,000 to 45,000 families of several members each are affected.

Opposed to the accepted idea that Americans dump their elderly in nursing homes, research has shown that nursing homes are used after families have exhausted their own resources. Usually, a nursing home is sought only after one or more primary care givers have become exhausted or ill.

A primary care giver is generally a spouse or a child. With our aging population, care givers are frequently elderly themselves. Care givers have been found to be involved from 1 hour a week to 84 hours a week. Most are involved 20 to 30 hours a week.

Several studies looked at the impact of care-giving responsibilities on families. Both benefits and costs have been reported. The benefits reported are seldom experienced by families of Alzheimer's patients–affection, enjoyment, help with housework and child care. Increased strain was related to low morale, interruption of routines, interruption of social and leisure activities, financial costs and increased ill health.

Seventy-five percent of the families caring for elderly who were mentally incapacitated characterized the care as a burden, and 40 percent of those referred to it as a severe burden.

Interpersonal relationships become strained, and evidence of abuse has been found in about 10 percent of the cases where people are being cared for at home. Financial costs of care-giving in the home create far less strain than do emotional factors. Strain related to the care-giving role has been found to be less when the care giver perceives that help and support are available from others.

That is where the Alzheimer's group becomes helpful. Families report great relief in knowing they are not alone in their suffering and that help is available in the community. Families are supportive of one another, but we believe greater support can be developed by training volunteers in helpful interpersonal skills. When faced with a distressed and stressed person, many of us have no idea how to respond and tend to back away.

One approach we are considering in Iowa is the development of a peer helper program, patterned after programs already in place in many of our schools. This program focuses on helping people understand themselves and others better, and teaches helpful interpersonal skills. Training is done by professionals, most of whom are not free to donate the time necessary. Family members and volunteers would be the participants.

Families provide a great amount of care for ailing elder members. Research indicates that they want to continue doing so whenever possible. We must begin to support families in their effort to provide necessary care to avoid large numbers of elderly being placed in nursing homes.

Thank you.

Senator **Grassley**. Thank you. Ms. Mann? I will ask questions when we are done with the whole panel, so if you will just stay at the table.

Proceed.

Ms. **Mann**. Thank you, Senator Grassley, and with your permission, I will not read my prepared statement but just highlight it with a couple of remarks.

Senator **Grassley**. Your entire statement will be printed in the record.

Ms. **Mann**. Our program, the OASIS program—Older Adult Service and Information System—is an attempt to meet a need that is not always articulated and defined. I think we have done a wonderful job in trying to meet the needs of housing and health problems, transportation, et cetera, but there are other needs that older citizens have.

Many people find themselves suddenly without the responsibilities of job and raising a family. The result is a sense of inadequacy, a loss of self-esteem, a great deal of depression, and we find this very prevalent.

Since 1976, I have been engaged in developing programs to meet this need. We mainly worked in the multipurpose senior citizen centers, providing classes in arts and humanities and continuing education, trying to reach people and say to them that they were not too old to learn; that the sort of things that we hear were myths, such as "you cannot teach an old dog new tricks."

This is certainly not true. Cognitive ability does not diminish, and people get a great deal of satisfaction from being able to create and to express themselves.

In an attempt to broaden the base from the community centers, we presented programs in a variety of community resources–libraries, museums, et cetera. And because the chairman of our advisory group was Mrs. Morton D. May of the May Co. department stores, we approached the local May Co. and asked for the use of their auditoriums twice a month; they were very responsive.

Over the years, we began to notice that we had an enormous number of people coming to anything that we presented at the department stores, and these were people that we did not see anywhere else.

After doing some simple surveys, we found that indeed these people were in need of stimulation, of some challenge, of some opportunities to socialize, but felt that the senior citizen centers were not places for them. I think we all realize that older adults are very much like younger adults, in that we are very different, and people have to have options.

They did not feel comfortable in places where they felt they were getting social services. A department store has a vitality of its own. It is naturally intergenerational and it is a very alive place, full of enticements, and our program is yet another enticement.

And so we approached the department store and the Administration on Aging, and fortunately Dr. Tolliver saw the opportunity and the uniqueness of the program to develop senior centers within the department store, which we have done.

We have, in just 18 months in St. Louis in three centers, 10,000 members. The department store provides a comfortable lounge, a volunteer desk that is manned by senior citizen volunteers 5 days a week, and we run classes in arts, humanities, physical education, wellness, history from the historical society, botany from the botanical gardens, et cetera.

It has proven to be a very successful program. We have had an enormous response. It is mainly run by older adult volunteers, which offers them another challenge. We have opened centers in October in the Hecht stores in Baltimore and the May Co. stores in Cleveland, and we are scheduled in downtown Los Angeles on May 22.

We feel that this public-private partnership is an exemplary one in terms of being able to leverage private funds by using some Federal moneys In 1 year, the Administration on Aging put $190,000 into this project. The department stores put over $400,000 into their portion of the program. This does not include executive time, nor does it include the contributions from the community—the kinds of classes we have had from the medical schools, et cetera—nor does it include the volunteer time.

We are also developing a handbook that we hope will be able to stimulate other communities and other businesses to do the same sort of thing. Our efforts for dissemination resulted in a very fine Associated Press article that appeared in about 54 cities, and we have been deluged by phone calls in response to the article.

We are very appreciative of the support of the Administration on Aging, and particularly Dr. Tolliver in her personal efforts to further this program. I think we are changing the attitude of some businesses toward the older adults, and not only in their responsibility toward them but as a vital part of their business.

[The prepared statement of Ms. Mann and responses to questions submitted by Senator Grassley follow:]

TESTIMONY BY MARYLEN MANN

DIRECTOR OF OLDER ADULT SERVICES AND INFORMATION SYSTEM
-OASIS PROJECT-

FUNDED IN PART BY THE UNITED STATES ADMINISTRATION ON AGING

Given Before the Senate Labor and Human Resources Committee
(Aging Subcommittee)
Tuesday, February 28, 1984

Senator Grassley and other members of the Committee, my name is Marylen Mann and I am Director of Older Adult Services of the University of Missouri-St. Louis and Project Director of OASIS. I am pleased to be here and be given the opportunity to tell you about this exciting project. We believe OASIS is unique not only in the public/private partnership created, but in the response on the part of thousands of older adults who by their enthusiatic participation have confirmed the importance and vitality of this effort.

The Older Adult Service and Information System (OASIS) is an exemplary demonstration of how effective planning and coordination by the Administration on Aging can leverage modest federal dollars into a major cooperative effort with the private sector. The result has been a substantial expenditure of time, funding and personnel on the part of private business and institutional concerns on a joint venture basis.

Before I go into what I think you will find to be an interesting story of how and why the OASIS program came into being, let me take just a moment to summarize for you the key components of our project:

- Educational, informational and cultural activities and programming are provided for older adults in a highly visible, accessible setting that has struck an immediate responsive chord in the older adult community--a special, reserved area in a local department store for members of the OASIS Club
- The older adult members directly participate in the development and operation of the program
- There are immediate economies of scale permitting participation by people from a broad spectrum of the community (more than 10,000 older adults are OASIS Club members in the three St. Louis centers alone)
- Successful transfer of the St. Louis model to Baltimore, Cleveland and Los Angeles confirms the replicability of OASIS on a cost-effective basis with increasing private sector involvement and responsibility

BACKGROUND/PROGRAM DESCRIPTION

OASIS is an effective response to the deterioration in the quality of life faced by a great majority of our older adults, regardless of economic or social status, geographic area, sex or religion. The older person finds that as the demanding responsibility of job and/or family is gone or materially diminished, there is a loss of purpose, a sense of inadequacy, a lack of self-esteem, all fueled by a perceived and in most cases real sense of loneliness and boredom.

For this rapidly growing population there is a need for quality of life beyond the basics of food, clothing and shelter--a need that society must address not only because our older population is entitled to age with dignity, but because a failure to respond to this need will result in accelerated physical and mental deterioration with correspondingly heavier demands upon the traditional social/medical service sectors of our society that have become so costly.

OASIS is a public/private partnership that provides an accessible structured opportunity for our older adult citizens to find new meaning in life, to expand their horizens, pick up old interests and learn new talents and skills--all directed toward the simple, yet necessary goal of maintaining a high quality of life to preserve the individual's sense of purpose and worth.

Enhancement of quality of life for the older adult has been provided to some extent in a traditional, senior center setting. But it has lacked the excitement, vitality and sense of being a part of life that the department store/shopping mall presents today. Unfortunately, this traditional setting almost insures substantial dependence solely on government funding rather than drawing upon private sector resources.

For several years in my work with older adult services, I had participated in developing and implementing programming to enrich the quality of life for older adults. Most of this programming was carried out either in senior citizen centers or other traditional institutional settings such as the public library, the art museum or university campuses. With the help and support of Mrs. Margie May, we were given the opportunity to use auditorium facilities at the St. Louis Famous Barr department stores for lectures and related programming. We found an immediate and enormously favorable response on the part of a vast number of older adults who historically either rejected or failed to use the traditional senior citizen network and institutional setting.

The idea of a senior citizen club and center sponsored by the store came with the realization that many of these citizens had negative feelings about such settings, but wanted and needed opportunities for socializing and enrichment. Fortunately, the Administration on Aging, and in particular Commissioner Tolliver, saw this as a unique and significant demonstration project.

The Famous Barr Department Stores in St. Louis responded by providing at their expense not only the auditorium facilities but a dedicated, nicely appointed and tastefully furnished area where the older adults could congregate for rest, relaxation and informal conversation over coffee or tea. In addition, the stores also provide special shopping discounts and special hours during traditional holiday shopping days for members of OASIS.

But the OASIS Centers provide much more than social and shopping events. They are also centers for education and information. Each OASIS area includes space to accomodate an art class of 20 or a presentation for 250, taught by professionals from area museums, cultural institutions, universities, hospitals, and businesses. A typical nine-week series of programs may include classes in arts and humanities, finance, physical education, health horticulture, and home repair. These classes are organized with the assistance of a broad-based advisory committee made up of individuals representing universities, cultural institutions, area agencies on aging, volunteer organizations, retirement groups, and businesses. The committee assists in locating and securing participation in the program by those people in the local community who have special information for, and skills to share with, older adults. Program offerings are thus high quality activities designed to stimulate and challenge. There is systematic evaulation by both presenters and participants which provides the basis for future programming. Whenever possible, classes are taught by skilled older adults.

Besides providing a location for education and socialization, the OASIS Centers provide a focus for access to other educational and recreational activities in the metropolitan area, as well as a resource for information about services available to older adults--a single place where one can go to find out about a range of events, activities and programs. Whether seeking information about energy assistance, free tickets to a local theatre production, or entry guidelines for an art show for seniors at the botanical garden, older adults can find what they are looking for at the OASIS Centers.

OLDER ADULT VOLUNTEERS

A significant aspect of the OASIS Centers is that they are predominatly operated by older adult volunteers. For many OASIS members, this opportunity to take part in the organization of the OASIS Center and in program planning provides a sense of satisfaction and purpose that is an important ingredient in enhancing the quality of their lives. For some it is an opportunity to continue to use skills developed during years of working outside the home, before retirement. For others it provides a new opportunity to contribute to and work with others after years of time devoted to homemaking. Older adults have many options in the kinds of volunteer activities available, ranging from operating the Centers, coordinating holiday events and providing information and referral services, to evaluating and observing classes and actually leading classes. Workshops and training sessions provide additional means for them to develop new skills in these areas.

PARTICIPATION AND GROWTH

The first OASIS Centers opened in May Company's Famous Barr Department Stores in three areas of St. Louis, Missouri, in September 1982. Since that time, 10,000 St. Louis area older adults have become members of OASIS and have taken part in regularly scheduled activities and classes. The program administration, housed in the Center for Metropolitan Studies of the University of Missouri-St. Louis, is assisting in the replication of OASIS in four other cities in cooperation with the May Company Department Stores, American Association of Retired Persons, and area agencies on aging. Currently, Baltimore, Maryland and Cleveland, Ohio, have OASIS Centers, and Los Angeles, California will open a Center in May 1984. City departments of aging together with cultural and service agencies are cooperating in the development of the centers.

The St. Louis program staff makes initial contact with the stores and identifies the appropriate coordinating organization in the local community. The staff provides training and materials to each city and assists in adapting the program model to meet the needs and resources of the local community. They also provide on[illegible] consultation and technical assistance for the duration of the developmental period.

The rate of increase in membership in the OASIS program has exceeded all expectations. By the end of January 1984, in addition to the 10,000 members in St. Louis, 1,000 older adults in Cleveland and 1,000 in Baltimore had joined OASIS. These two cities opened their centers in October 1983.

SIGNIFICANT RESULTS OF THE OASIS PROGRAM

The OASIS program attracts a broad range of people to a location that is rich in alternatives. Members are not limited in their participation by income, religion, or neighborhood. Members can obtain information about important services and take part in enriching activities without being identified or being labeled as in need of service. They are provided with a dignified, stimulating, and interesting place to spend time and an attractive setting in which to acquire new friends, discover new activities, and take part in new learning. They are provided opportunities for challenging volunteer activities and involvement in organizational activities.

Beneath this umbrella of enhanced quality of life, better services to and better communication with older adults can take place. The OASIS program is a vehicle through which important messages can reach the older adult audience, particularly in the areas of mental and physical health maintenance. As an example, one of the programs that was particularly well received was a health series presented by the staff of the Washington University Medical School. The doctors and nurses who presented the material were so impressed with the interest and involvement of the participants and by the large number who attended, that several proposals have been developed for further cooperative efforts between the medical school and OASIS, in the areas of both research and health maintenance education.

Through its unique public/private partnership OASIS is bringing together organizations and institutions who have never had an opportunity to work on a cooperative project before. Both individuals and institutions are becoming aware of the need for programming for older adults and of the tremendous response such programming generates.

OASIS HANDBOOK

An important product of the OASIS project will be the OASIS Handbook, which will be published by July 1984. The Handbook will provide guidelines and sample materials for communities and organizations interested in starting OASIS projects.

COST EFFECTIVENESS

As a community-spirited business Famous Barr Department Stores made a considerable investment and took a considerable risk in the establishment of the OASIS program. Not only did the stores provide space for the Centers, they furnished comfortable, decorated areas and equipped the Centers with volunteer desks and phones, together with tables and chairs for classes and lectures. The stores continue to provide supplies, refreshments, audio-visual equipment, discounts, gift certificates, and to print brochures and flyers. Store executives have concluded that the support of the OASIS program is a public relations success and a worthwhile investment. Famous-Barr in St. Louis, The Hecht Company in Baltimore, and May Company in Cleveland have received national publicity in the last several months. An Associated Press article recently appeared in newspapers across the country stimulating a great number of calls to Administration on Aging offices in Washington and to OASIS administrative offices at UMSL.

The investment also has been an excellent one for the federal government. The $190,000 which provides this broad range of services and activities for over 12,000 older adults for an entire year has generated several times that amount in private sector contributions. One year of contributions from the three May Company Department Stores that participate in OASIS amounts to over $400,000. In addition to this are many more contributions from all the many organizations and businesses who provide free services and programs to OASIS members. A further critical component is the coordinating organization in each city: the Mayor's Office on Aging in Baltimore; the Department of Aging and Board of Trustees of OASIS in Cleveland; and the Area Agency on Aging in Los Angeles. Finally, thousands of volunteer hours are contributed to ensure the success of all of the programs.

Programs themselves aimed at maintaining physical and mental health and in teaching new methods for living healthier, longer lives will result in a healthier older adult population who will spend fewer health care dollars. The effectiveness of the program can further be demonstrated by its flexibility. Centers in St. Louis are in one city location and two county locations, each with diverse demographic mix. In Baltimore, the Center is in a shopping mall in a suburban area. In Cleveland, the Center is in the downtown store in an area with many federally subsidized apartments for senior citizens.

In Los Angeles, the Center will be located in the downtown store in an area with a varied ethnic population. Furthermore, regardless of the population in the immediate area of the store where the Center is located, OASIS draws from a wide geographic area. Demographic studies have indicated that older adults come from every part of each city to participate. The choice of the department stores as center sites has proven effective. They are accessible and do not have the connotation of the social service provider. The department store population is already a mix of neighborhoods and social strata.

THE KEY ROLE OF THE ADMINISTRATION ON AGING

The Administration on Aging has played a key role in the development of the OASIS program. Staff members have been open to new ideas and remain willing to explore alternatives. At the same time they require programs to meet high standards for both criteria and cost effectiveness.

Dr. Lennie Marie Tolliver, Commissioner of the Administration on Aging, has been particularly supportive and understanding of the OASIS project. Her participation in meetings with department store officials and in representing the Administration on Aging at openings of the Centers was an important catalyst in generating and maintaining community cooperation and support. In addition, she has facilitated our contact with other governmental agencies who might find the OASIS program of interest--agencies such as the Surgeon General's Office and the National Institute on Aging.

Community programs such as OASIS have benefitted greatly from professional training, education, and research supported by Title IV. The need for such support is large and growing larger every day. Seed money from the Administration on Aging has been, and will continue to be, essential to the development of innovative public/private social service projects such as OASIS. The initial federal funding was the essential ingredient in leveraging private funds and local community support. In the OASIS program the Administration on Aging has shown how a relatively modest sum of federal money can be effectivel used to establish vigourous and self-sustaining programs.

The key to the success of OASIS has been not only that it fills a deep need in an imaginative way but also that there are real and substantial rewards for both the public and private partners in the activity. But the rewards have to be demonstrated and experienced in order to be appreciated. The basic funding and the supportive monitoring by the Administration on Aging have made it possible for the partners to experience these rewards in St. Louis, Baltimore, Cleveland, and--in the near future--in Los Angeles. It is hoped that this project is just the beginning of a large number of similar projects across the country involving many thousands of older adults.

Older Adult Services/OASIS Project
    Marylen Mann, Director
    Ann Risdon, Assistant Director
    Betty Hayes, Administrative Assistant
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QUESTIONS FOR MARYLEN MANN FROM SENATOR CHARLES GRASSLEY

1. Will the OASIS project be able to continue when federal funding stops?

2. What role do seniors have in planning the program?

1. It is anticipated that after stores have absorbed the initial costs of remodeling and furnishing the physical sites for the OASIS Centers they will be able to assume the costs for continuation. This will be a decision to be made by each store in each city where there is a Center.

   Also, as has already happened in Cleveland with a donation of $10,000 from the Cleveland Public Library for programming, it is hoped that there will be outside funding from within the communities where the OASIS Centers are located.

2. Seniors sit in on Older Adult Services Advisory Committee and Program Planning Committee meetings. They design quarterly programs and provide suggestions for classes and program improvement. All class enrollees are requested to complete evaluation forms.

   Older adult volunteers participate in all phases of managing the Centers. They attend monthly meetings for problem solving, suggestions, and updating of materials. Many of them serve as teachers, group leaders, and on committees to plan and to coordinate special events.

Senator **Grassley**. Thank you very much.

Go ahead.

Mr. **Affeldt**. Thank you, Senator Grassley. As you requested, we shall focus our testimony on the association's assumption of the Administration on Aging SCAN project. SCAN, as you know, was created when the National Information and Resource Clearinghouse was established, and one of its major functions was the computerized retrieval of information in the field of aging.

The underlying objective was to provide a centralized data base where persons interested in gerontology could obtain information that would not otherwise be readily accessible. The 1981 Older Americans Act amendments terminated the National Information and Resource Clearinghouse. AOA sought alternative means to continue this activity through the involvement of the private sector.

AARP submitted a proposal in January 1983 to AOA to continue the computerized data base component of SCAN because the association believed that this service was both useful and worth preserving.

The Gerontological Society of America and the Association for Gerontology in Higher Education were cosponsors of the proposal to assist AARP in collecting information on research projects and education and training materials. AARP was awarded a contract in September 1983. The entire cost of this project is borne by AARP.

This activity is called AgeLine, and is administered by the AARP National Gerontology Resource Center. We are unable to provide the subcommittee with a complete report at this time because AgeLine has been in existence for only 5 months and is still under development. We expect the system will be fully operational in June.

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AgeLine will provide computerized access to aging literature. By emphasizing the social, psychological and economic aspects of aging, it is designed to complement the National Library of Medicine's Medline system, which provides doctors, researchers and others with access to geriatric literature.

AgeLine will become available for public use during the latter half of 1984. Nominal charges will be imposed for users of the computerized system.

Our experience with AgeLine has been brief, but the system shows promise of working well. We feel that it provides vital support for researchers in the field of aging, since there is no other system that identifies and indexes the literature comprehensively.

To date, the AgeLine system has accomplished the following: approximately 2,500 journal articles, research reports and books have been indexed and abstracted from 1982 to date.

About 8,000 additional records on tape have been converted and standardized for the system. Another 4,000 records are being entered into the system. About 2,000 records citing federally funded research projects on aging are currently being converted and standardized for the system.

When the system is available in June, it will contain approximately 15,000 citations to aging literature and 2,000 reports on aging-related research. AgeLine will be an ongoing activity with about 3,000 new records added each year. We believe this is an essential activity because aging is a dynamic field which requires up-to-date information.

Our relationship with AOA in undertaking this responsibility has been good. There has been close cooperation between both parties in working out the details of the system. AgeLine will be a useful and cost-effective information retrieval system for practitioners, researchers, and other users. It has great potential, but we must recognize that the system has limitations. It is important to realize what the system will do as well as what it will not do.

It will generate indexes to the literature and produce bibliographies on various aging-related topics. By citing published works in gerontology, it can help to identify researchers and specialists with expertise in given subject areas. Moreover, it can report the results of research projects and describe aging programs which can help to facilitate the transfer of information among practitioners in the field of aging.

AgeLine, it must be remembered, is a data collection and reporting system. It does not, however, analyze the information nor identify trends or emerging problems. No current program systematically reviews research in the field of aging. This is one of the most serious gaps in the research field today.

We believe that it would be desirable for the AgeLine system to incorporate this type of activity, and this can be done for a relatively modest cost. This activity could be undertaken by an organization such as the Gerontological Society of America, for example.

We believe it would also produce very significant dividends. For example, it could provide comprehensive and up-to-date information and analysis to assist policymakers in making sound judgments on issues of direct concern to older Americans. It could promote the transfer and use of existing data by researchers, scholars, and others.

I see the red light is on; I will be finished in just about 30 seconds.

In addition, it could provide information about best practice model programs that have worked successfully. These models then could be replicated by others.

We believe that these additional activities would enhance the existing AgeLine system and make it even more valuable for those who use it. AARP is strongly committed to making the AgeLine system effective, workable, and available to the aging network.

Once again, we welcome the opportunity to provide the subcommittee with a status report on the progress of AgeLine. We, of course, are available to respond to any questions that you may wish to raise. Paula is our technical expert here and you may want to address your questions to her.

Senator **Grassley**. OK. We had several questions; we still do have, but some of those have been answered as I have listened to your testimony.

Now, you have this information available, so the natural question is, How will the public be able to gain access to the information that you have in the system. Maybe my question demonstrates lack of knowledge about the system, but is there going to be direct telephone access, as an example?

Ms. **Lovas**. The public will gain access to the system through a commercial vendor service, where these tapes will be mounted on a system that is available to anyone with a computer terminal. That access is a telephone access using a computer terminal.

We will have access, we think, to the system ourselves, apart from the vendor, through the contractor who is putting the service together for us. We hope in that way to be able to do some less costly searching by bringing the system up; it will not be constantly online, but we could bring it up at the time that we want to use it.

I should say that in many respects it is not a public service, per se. It is certainly available to the public to use, but it is a system that collects primarily professional literature and professional level publications, so that I see it being of primary value to researchers, practitioners, academic personnel, persons in the private and forprofit sector who may be doing research in the field of gerontology. But it certainly would be publicly available.

Senator **Grassley**. How long is AARP's commitment to this system? Is it permanent, as far as you can see into the future?

Ms. **Lovas**. Yes, this is an ongoing commitment.

Senator **Grassley**. What methods will you use to publicize the data available in the system generally?

Ms. **Lovas**. We will be doing mailings when the system is closer to being usable. We have been somewhat reluctant to publicize this system too widely, partly stemming from my personal belief that one of the biggest problems SCAN had was that it promised before it was really able to deliver.

We do not want to go out promising access to a system until we really do have it ready to use. We will be doing the mailing, however. We received from the Administration on Aging a mailing list of

4,000 names, persons who had indicated interest in the system before. So we will be doing newsletters and briefings to them.

We are funded to do some training activities at conferences and at meetings. We will be encouraging staff to call the Resource Center for assistance in using the system. Those are our basic educational plans.

Senator GRASSLEY. Will title IV-funded project reports continue going to this system?

Ms. LOVAS. Yes, they will. The 2,000 records of federally funded research in aging that were mentioned in the testimony are from all Federal agencies, not just AOA. We would ideally like to keep that file broader than just AOA research.

However, at a minimum, we will be updating with project information from AOA.

Senator GRASSLEY. Is there a formal agreement with AOA to the effect that you will continue to receive their information?

Ms. LOVAS. Yes, there is. There is a letter of understanding that was signed in October.

Senator GRASSLEY. What is the role of the Gerontological Society and the Association on Gerontology in Higher Education in this project?

Ms. LOVAS. Well, I would say the cooperative arrangements that we have with these two organizations is largely an interest that we felt very strongly in working with these organizations as representatives of the aging network.

The Gerontological Society will be working with us in identifying research projects and in collecting material and information relating to research projects. The Association for Gerontology in Higher Education has taken over responsibility for the educational and training materials which were a part of the system.

[Responses of Ms. Lovas to questions submitted by Senator Grassley follow:]

QUESTIONS FOR PAULA LOVAS FROM SENATOR CHARLES GRASSLEY

1. Are you familiar with H.R. 4485, which would establish a clearinghouse in the Administration on Aging? Are you able to comment on this bill for us? Your comments could be helpful because this Subcommittee may have to consider a similar bill in the Senate, or may have to discuss this issue in House-Senate conference on the Older Americans Act.

2. Does AARP intend to do any deep or more intensive assessment or analysis of reports which come into the "Age Line" system? If not, how difficult would it be to do such analyses of what's been funded and what research and demonstration gaps are? How much would it cost?

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

May 25, 1984

Senator Charles E. Grassley
Chairman, Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Senator Grassley:

I am writing in response to your questions addressed to me in your letter of April 10, 1984.

We are familiar with H.R. 4485, having studied it closely and having met in December 1983 with Representative Biaggi's staff to discuss our concerns about this bill. As you are aware, many of the functions of the former National Clearinghouse on Aging were awarded to AARP's National Gerontology Resource Center, as the result of a proposal we submitted in response to AoA's RFP published in the December 1, 1982 Federal Register. We believe that the primary activity proposed in H.R. 4485 - that is, the mandate to compile, archive and disseminate information relating to current and recently completed research, demonstration, evaluation, and training programs and projects related to aging - will be accomplished to a large degree through the AgeLine computerized information system that AARP is now producing, based on the materials we received from AoA as part of the SCAN information retrieval system. We expect the AgeLine system to be publicly available within the next several months. Having assumed responsibility for this system, without benefit of federal funds, we believe that this system should be given an adequate chance to demonstrate its capabilities and utility before new federal funds are committed to any new, broad-based information program in aging.

It is quite clear to us that any information program of the scope proposed in H.R. 4485 would have to include the establishment of a large and complex computerized information storage and retrieval system to accomplish its objectives; such a system would be a direct and costly duplication of the effort that AARP is now making to provide a comprehensive and timely information retrieval system for the field of aging.

Arthur F. Bouton
AARP President

Cyril F. Brickfield
Executive Director

National Headquarters: 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

By its emphasis on the collection and dissemination of information from research project reports, H.R. 4485 overlooks a basic element of information dissemination - namely, that the initial or breakthrough findings from research projects are normally reported first in the journal literature, or often as conference papers, long before the project final report is written. Placing emphasis on project reports as the most important source of information for the aging network or policy makers contradicts the findings of most research in the field of information transfer. Research indicates that the journal literature, conference participation, and informal contacts with colleagues are all more frequently used information sources than are published project reports. The AgeLine system, like the predecessor SCAN system, attempts to address this fact by incorporating a substantial body of journal literature, as well as conference reports. While this prolongs the time it takes to get the system operational, we believe that it contributes in the end to a much more comprehensive and useful information retrieval system.

In addition, H.R. 4485 is not clear in describing what is expected, or intended, to be covered by this new information program. Although the initial emphasis appears to be on Title IV research, the following language appears in the bill:

- "projects related to aging conducted in whole or in part with funds made available under this Act or any other statute of the United States."
- "ensure that information is available concerning any programs, services, and benefits, both public and private, which are not federally administered and for which older individuals may be eligible."
- "the Director shall take into consideration the results of related programs and projects...made available by any organization or non-Federal agency."

In summary, the language of this bill is unclear and non-specific in defining what is the purpose of this program, what information is to be collected, how it is to be disseminated, and who is the intended audience - all crucial questions that must be addressed before any successful information service can be established.

In response to your second question: At the present time, AARP does not expect to do any deep or more intensive assessment or analysis of reports which come into the AgeLine system. We agree that this is a function that is much needed, and are hopeful that a good information analysis program can be established for the field of aging. We expect that the AgeLine system will be an invaluable tool for anyone undertaking such a project, since it will greatly simplify the task of identifying and locating relevant information. It is difficult for me to estimate the cost of such a program, but I would suggest that a reasonably good information analysis program could be conducted for approximately $300,000. You may be aware that the Gerontological Society of America currently has a proposal for an information review and analysis program, which it has submitted to AoA and other possible funding sources, and I believe that the figure of $300,000 is in keeping with their estimates of what such a program would cost.

I apologize for the delay in responding to your questions, and hope this information is helpful to you.

Sincerely,

Paula M. Lovas

Paula M. Lovas, Head
National Gerontology Resource Center

cc: Dave Affeldt

Senator GRASSLEY. Thank you.

Mary, on another point in regard to Alzheimer's disease, there are several bills in, as you have heard at this hearing, in regard to amending the Older Americans Act by placing in title IV several provisions relating to Alzheimer's disease.

Have you had a chance to read any of these bills?

Ms. OLIVER. I have looked them over, yes.

Senator GRASSLEY. Well, I am glad that you have. Can you tell us what you think of those provisions?

Ms. OLIVER. The one that I was most interested in commenting on today was that instead of perhaps always addressing Alzheimer's disease and those families, the whole concept should be a little broadened to include all caretakers of other kinds of illnesses, also.

Senator GRASSLEY. OK. As you relate your knowledge to the Older Americans Act, do you have any idea whether or not provisions on Alzheimer's disease ought to be included in title IV or some other provision in the act, like title III?

Ms. OLIVER. Title IV seems appropriate, as I understand the bill, in that it is providing more of an indirect support. I think you can reach a broader base of people with that type of support.

Title III provides some specific services, but with a group of Alzheimer's families, what you need is a broad base of support, not necessarily specific services. Now, they may become necessary at some point in time, but right now the families are very isolated for the most part, alone with their problems, and they need a large group of people who can be helpful to them.

Senator GRASSLEY. You mentioned that 40,000 to 45,000 people in Iowa alone might be affected by this disease or diseases with similar effects. Now, that is a tremendous problem of care and costs associated with it, whether you are talking about public funds or private funds.

I do not know to what extent we are able to help a large portion of the families who are caring for these people, but how many people would you say the 18 support groups that you mentioned in Iowa are reaching of these 40,000 to 45,000?

Ms. OLIVER. I would guess less than 1,000.

Senator GRASSLEY. Less than 1,000?

Ms. OLIVER. Yes.

Senator GRASSLEY. Do you think that the kind of approaches that your organization is using in Iowa have the potential to eventually reach and help most of the families of the people in the State who are suffering from these kinds of disorders?

Ms. OLIVER. Yes, I think so. The format that we use is support group meetings. We are wanting to expand what we do now. When we have a monthly meeting, we have 45 to 50 people come. It is mostly educational in nature, with some support.

We are wanting to expand that to a number of small support groups that would be 8 to 10 families in more localized areas. In this way, we can reach people in their homes.

We also want to broaden the telephone network because many of these folks are so disabled that they cannot be taken out by family members. So the use of the telephone, particularly in our rural State, becomes a very useful tool.

Senator GRASSLEY. Marylen, is the OASIS project planning to reach beyond department stores as settings for the kind of activities that you sponsor?

Ms. MANN. Yes; as a matter of fact, our next target is the Florida Power & Light Co. in West Palm Beach. We have gotten a number of requests from other types of businesses that also could present a program that is not stigmatized by social service, but depends really on business. That will be our very next target after Los Angeles.

Senator GRASSLEY. I would like to have you expand on the point you made that some older people are willing to get involved in the kind of activity as it relates to department stores, but might not be willing to do the same thing, like, for instance, if it was carried on in a senior citizens center. Could you expand on that?

Ms. MANN. Yes; I am always hesitant because it is difficult to be critical of the senior citizen centers; they do a marvelous job. However, there are people who will say, "that is where you get the free lunch."

The kind of neighborhood setting that the senior citizen center offers is very comfortable and very adequate for a lot of people, but there are others whose experience and whose background go beyond that, and they feel uncomfortable in that sort of setting.

As I said, the department store cuts across all social lines, all economic lines, and it is a very enticing atmosphere.

I think one of the things that we are doing in the department stores that has been difficult to do in the senior centers is offer really quality programming, the kind of quality programming that you find on college campuses.

But a college campus also presents another threat. There are many people who, after many years of not going to school, feel very threatened by going on a college campus. We are presenting that same high level in a setting that does not threaten and has no negative connotation.

Senator GRASSLEY. Is there a general lesson here with respect to whether some of our programs may themselves contribute to the age stereotyping of older people, or at least that some older people may think that they do?

Ms. MANN. I think so. I think there is a danger in assuming that all older people are alike and respond to the same sort of offerings, and I think it is terribly important that we have a variety.

I think we are getting a new group of older people. They are going to stay healthier longer. I hope that we can help, and that is another big effort that we are trying to make in behavior modification and health attitudes on the part of the elderly.

They are healthier; they have had more education; they are a bit more sophisticated. They have grown up with television, and the whole world is in their living room, and I think that we have to be aware of this and not give people things that just fill their time.

I think the important thing to remember is that even if you are fed and even if you are being taken care of in many ways, you have to have a reason to get up in the morning. This is going to be more and more true of the people who are retiring at 60 and 65 when they are still almost at the peak of their capability, and suddenly we tell them that they are no longer useful.

Senator **Grassley**. I have got so many reasons to get up in the morning, it almost makes me want to stay in bed.

Ms. **Mann**. I understand. I hope it is always that way for you, Senator.

Senator **Grassley**. I think you spoke to this next and last question. Did you not say that the administration has been helpful to you in your project? And if you did not say that, my question is have they been?

Ms. **Mann**. Yes, they have been very helpful. This is sort of a nontraditional project in a nontraditional location, and they have recognized the potential of it. I think one thing that has been very important is that the Commissioner has been willing to come out and meet with the department store executives and come to the openings.

They have been very impressed at being able to interact with a representative of Government. We often lose sight of the fact that these agencies have names and faces and are populated by real people who really do care what happens.

We have drawn huge crowds to these openings in the department stores, and I think it has been good for the department store executives to talk to her and for the people in these communities to see her and to see that there is support for this kind of private involvement, and that it is important. It has made a lot of difference.

Senator **Grassley**. I do have one more. I thought you had addressed everything, but you mentioned several proposals that have been developed between the Washington University Medical School and OASIS for further cooperative efforts in health maintenance and promotion. Could you expand on that a little bit?

Ms. **Mann**. Yes. The interesting thing about it is we have had a lot of doctors and researchers who have been willing to come to lecture and they have been very impressed by the enormous crowds that we have drawn and by the kind of intelligent questions and the kind of interest that has been generated.

We got together and decided that with their expertise and with the number of people that we have and the involvement that they want, we really need to do something about developing programs aimed at improving health maintenance and health attitudes.

Right now, what we are doing is putting together a program for the prevention of hip fracture. The Commissioner has been very helpful in introducing us also to other agencies. NIA and the Surgeon General's office have combined to take a look at this.

We are hoping that it will be funded. It will be a 6-year project that would result in a risk factor index on what are the really high-risk factors in hip fracture, developing an educational program that we could give through our centers across the country, and early intervention techniques.

I think that this is just the beginning of many such programs that we can put on, and the hospitals and the medical schools really seem very responsive to this particular setting. It is much more difficult for them to go to the small group centers than it is to our programs where they know they are going to reach a lot more people.

Senator **Grassley**. This has been a very good panel. I want to thank you all very much and encourage you to keep in touch with us as we actually get down to the writing of this legislation and the consideration of it. Thank you very much.

Ms. MANN. Thank you for the opportunity.

Senator GRASSLEY. Again, I have to thank the next panel, Ms. Eleanor Cain, director of the division of aging of the State of Delaware, and Mr. William—I am sorry; how do you pronounce that?

Mr. ORZECHOWSKI. Orzechowski.

Senator GRASSLEY. Orzechowski, and you are director of a AAA in Pennsylvania. Now, I know that this is your first appearance before the committee in our consideration of this act, but both of your organizations have been very helpful to us at each hearing we have had. So, I have to thank the National Association of State Units, as well as the N4A organizations for contributing so much to this.

Eleanor is director of the division on aging of the department of health and human services of the State of Delaware and she speaks for the State units today.

William, you, I understand, are director of the North Central Pennsylvania Office of Human Services, Ridgway, PA.

I would ask you to start, Eleanor, and then go to you, William.

STATEMENT OF ELEANOR CAIN, DIRECTOR, DELAWARE DIVISION ON AGING, REPRESENTING THE NATIONAL ASSOCIATION OF STATE UNITS ON AGING; AND WILLIAM ORZECHOWSKI, DIRECTOR, NORTH CENTRAL PENNSYLVANIA OFFICE OF HUMAN SERVICES, REPRESENTING THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Ms. CAIN. Good morning, Mr. Chairman. As you stated, I am Eleanor Cain, director of the Delaware Division on Aging, and immediate past president of the National Association of State Units on Aging.

I am pleased to have the opportunity today to present the views of NASUA on the 1984 reauthorization of the Older Americans Act as it relates to title IV training, research, and discretionary projects and programs.

NASUA has consistently and strongly supported the original intent and subsequent evolution of the title IV discretionary grants program since it was authorized into law in 1965 as a companion to the title III categorical service grants programs.

The discretionary grants program was created to advance research, education, and training related to the act's purposes. Congress sought to provide the necessary support for expanding our knowledge base on problems and needs of America's elderly; for designing and testing innovative ideas for practice; and for training personnel across a wide spectrum of occupations to carry out the act's programs.

Consistent with its two major missions—systems building at the Federal, State, and local level, and advocacy—the Administration on Aging was assigned discretionary authority to expand the Nation's knowledge base on aging, as well as to help meet the need for more qualified and trained personnel in the field.

Guidelines for discretionary grants have been broad in scope, allowing AOA sufficient flexibility to incorporate new insights gained through research for program planning, and to develop vehicles for training that would be responsive to changing personnel needs.

Throughout its history the title IV program has, at its best, resulted in research projects that have produced knowledge needed by policymakers, managers, and practitioners at the Federal, State and local level; demonstration projects that have applied research findings for developing new and improved services and service delivery systems; and manpower and training projects that have incorporated and disseminated information generated by those other programs to facilitate improved practices in the field.

Today, Mr. Chairman, NASUA wishes to make a number of suggestions for statutory changes in title IV which we believe will further strengthen the capacity of the Administration on Aging to provide leadership in aging research, training, and demonstrations.

First and foremost, we urge this subcommittee to do what it can to help restore the dramatic reduction in funds, which was 59 percent, which have been available to this program since 1981.

We believe that the 1984 reauthorization of title IV should, at a minimum, include authorizing language to restore funding levels to those appropriated in fiscal year 1980. The current level of $22.1 million barely allows this program to advance the frontiers of aging research, training, and model projects so desperately needed to serve an expanding aging population.

The administration's recent shortsighted request to decrease the funding for this program to $5 million in fiscal year 1985 should be resoundingly rejected by those concerned with ensuring the future well-being of the older population.

Second, we urge this committee to deconsolidate title IV, providing for separate program categories and authorization of funds for research, education, and training, and model project demonstrations.

In addition, the scope and purpose of each of these program categories should be clearly delineated. We believe that it would be useful for the Congress to underscore its support for each of these critical aspects of a comprehensive discretionary grants program.

While this approach would provide the Administration on Aging with additional congressional guidance on funding priorities, it should not serve to hinder AOA's ability to incorporate new insights gained through research for program planning, nor to develop training mechanisms responsive to changing personnel needs.

Third, in a related issue, Mr. Chairman, NASUA last week before this committee recommended that the statutory and discretionary provisions of the act which currently support the administrative, advocacy, and training/professional development functions of State units should be consolidated.

State units are currently funded under title III-A for basic administrative costs of the State plan on aging, title IV for advocacy assistance efforts, title IV for State education and training efforts.

NASUA believes that it is in the best interests of public accountability and scrutiny to consolidate these provisions. Therefore, we urge the Congress to allow State units to use up to 5 percent of title III funds for administration of the state plan, with an established minimum base of $500,000.

NASUA has, since 1965, taken pride in the efficient state administration of this dynamic program. We believe that this proposal will institutionalize this traditional practice, but at the same time clearly identify all applicable administrative costs for review and comment during public hearings on the State plan, and make explicit the State responsibilities for advocacy and education and training activities.

Fourth, NASUA continues to support the prohibition against the comingling of Older Americans Act funds with those of other programs. Title IV appropriations should be used specifically for identifiable aging-related activities.

Fifth, we believe it would be useful for the Administration on Aging to prepare a detailed annual report which describes the activities supported under title IV. NASUA has had a longstanding concern about the dissemination and appropriate utilization of research and demonstration findings.

We understand that AOA is in the process of developing a comprehensive dissemination strategy. We look forward to working with them to enhance this important aspect of the discretionary program, and we urge this committee to underscore the significance of such efforts.

Thank you, Mr. Chairman, for your consideration of our views on the future of the title IV program.

[Responses of Ms. Cain to questions submitted by Senator Grassley follow:]

QUESTIONS FOR ELEANOR CAIN FROM SENATOR CHARLES GRASSLEY

1. With respect to commingling, staff of the Office of Human Development Services have assured us here today that the Commissioner must sign-off on any Older Americans Act funds used for grant awards, and that AOA assigns staff to monitor each and every grant project in which Older Americans Act money is invested. I believe you heard Mr. Torrado's testimony earlier.

Do you feel reassured on this commingling issue, and, if not, why not?

2. The Federal Council on Aging has proposed that a purpose section be placed at the front of Title IV. Some other organizations have also advocated addition of a purpose section to Title IV, although the language of these several proposals differs. The reason for adding such a section would be to give greater focus and direction to the Title IV programs.

Does NASUA agree that a purpose section is called for in Title IV?

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NASUA

NATIONAL ASSOCIATION OF STATE UNITS ON AGING
600 Maryland Ave., S.W., #208, Washington, DC 20024 • (202) 484-7182

QUESTIONS FOR ELEANOR CAIN FROM SENATOR CHARLES E. GRASSLEY

1. Commingling of AoA Title IV Funds

NASUA continues to support the current statutory provisions in the Older Americans Act which prohibit the commingling of OAA funds with those of other programs. Title IV OAA funds should only be used to support projects on identifiable aging issues consistent with the objectives of the Act. We believe that committee report language to this effect would be helpful in clarifying congressional intent of the current statutory provisions.

2. Title IV - Purpose Statement

NASUA believes that it would be useful to deconsolidate Title IV and provide separate program categories and authorization of funds for research, education and training, and model projects/demonstrations. In addition, the inclusion of a statutory "purpose" statement for all of Title IV would be most useful in demonstrating congressional intent. We, therefore, strongly support the language included in the Subcommittee markup in Section 401 - "Statement of Purpose".

Senator **Grassley**. William? Then I will ask questions when you are done.

Mr. **Orzechowski**. Good morning. As you indicated, I am Bill Orzechowski—"Bill O" is fine—from rural northcentral Pennsylvania, and a member of the board of directors of N4A. N4A, as you are probably aware, represents approximately 660 area agencies across the country. We very much welcome this opportunity to give you our thoughts on title IV.

The legitimate needs of the aged are complex and changing, and the approaches to those needs themselves are evolving. Title IV is critical to our capacity to evolve as a network of service providers to meet those responsibilities placed upon us.

Section A of title IV, State education and training: the Administration on Aging has granted to State units on aging a total of approximately $2.8 million per year in recent years. This is a reduction from $4.5 million in 1980. In many cases, these are the only moneys available to the area agencies for training purposes.

The amount received by the State of Pennsylvania, for example, currently amounts to only $27 per year per employee of area agencies and their client service subcontractors. This money is badly needed at the State and especially the area agency level for many reasons.

Formal education of most area agency and subcontractor staff makes on-the-job training extremely important. Seventy percent of area agency staff have had no college education. Second, the application of new technologies and the latest appropriate management techniques are essential to the aging service delivery system's continued accountability and effectiveness.

Examples in this category would include development and utilization of informal care networks, management techniques utilizing standardized service definitions and unit costing, and computer applications for client tracking and fiscal management.

Third, title IV-A funds have been successfully used to leverage private sector funds, and we provide some examples in the written testimony.

Another section A program which has been significant to the aging network at the local level has been the career preparation program. We must not underestimate the impact this has had on providing quality personnel to the field of aging. For example, in the St. Petersburg area agency and in N4A itself, there are many graduates of that program.

Section B of title IV: the advocacy assistance grants made to State units on aging to assist them to develop long-term care ombudsman and legal services for vulnerable older persons have proven particularly important, and even more so since the board and care homes have been incorporated within the definition of long-term care facilities.

Of the $2.6 million allocated to states in 1981, $135,000 was passed on to area agencies for ombudsman activities involving local advocacy efforts.

Demonstration projects, impact grants and long-term care initiatives all are important activities under section B of title IV. The long-term care initiatives, for example, are of great importance to area agencies due to the responsibilities they are accepting at the local level in direct response to growing general public awareness of long-term care needs.

The role of coordination of service components, both formal and informal, is increasingly expected of the area agencies. These locally expressed expectations complement the general awareness in all levels of government that the development of an affordable long-term care system is one of the greatest challenges we face in coming years.

There are two major long-term care initiatives which have been addressed earlier in various ways in today's presentations.

Training, education and research are the very processes upon which our future depends, particularly as related to long-term care. Most of our clients and ourselves at some point will need appropriate and affordable community-based long-term care.

In addition, and very importantly, to the extent that the long-term care system is carefully developed, our ability to afford to continue to meet other legitimate needs of the aged will be to a great extent determined.

I would like to point out that N4A itself has played an important part in achieving the title IV initiatives to date. Through information dissemination, studies of area agencies' capacities and needs, development of training materials, and its role in the development of a national data base on aging, N4A continues to do its part.

Now, for our recommendations concerning title IV, first N4A supports the investment of greater resources in education and training, research and discretionary programs under the act through increased authorization levels and appropriations. Investments in these areas are currently as low as can reasonably be expected to achieve any meaningful results. Note that funds currently are only at 41 percent of 1980 levels. The administration's recommendations would drop that to approximately 10 percent of 1980 levels.

Second, N4A suggests title IV should be deconsolidated and separate program categories—research, education and training, and demonstrations—should be restored. The scope and purpose of each program should be spelled out clearly and consideration be given to emphasizing specific targeted activities, some of which were discussed in previous testimony today—Alzheimer's disease, and so on.

To strengthen the training responsibilities of the act, and in accordance with the intent of recommendation No. 2 N4A believes that specifically those training and education funds essential to the direct provision of client services by area agencies and their subcontractors—that would be training of their staff, and so on—plus the client service activities of ombudsman and legal services granted to state units, should be incorporated under the responsibilities of title III.

N4A strongly believes that increased proportions of these training funds should pass through to area agencies on aging to perform these critical services at the local level. These title III-B related training responsibilities should be funded through additional authorization and appropriation levels.

States and area agencies would perform the same types and levels of work, but should benefit from a single planning, allocation and contracting process rather than two processes or, in a sense, for the state units, three processes.

Given the importance of the responsibilities and activities that would remain under title IV, N4A suggests that, at a minimum, current title IV funding be maintained at current levels.

N4A recommends title IV discretionary funds not be comingled with other Office of Human Development Services funds or any other programs. Older Americans Act appropriations for training, research and demonstration projects should be used specifically for identifiable aging-related activities.

Reporting and information dissemination provisions under title IV should be greatly strengthened. All too often, the benefits of the resources invested in research and demonstration projects are unknown due to inadequate dissemination. We suggest clear dissemination requirements be placed upon title IV grantees, for example.

This concludes my testimony and I would like to thank you very much for this opportunity on behalf of the association and myself. I would be happy to answer any questions.

[Responses of Mr. Orzechowski to questions submitted by Senator Grassley follow:]

QUESTIONS FOR BILL GRZECHOWSKI FROM SENATOR CHARLES GRASSLEY

1. Does the National Association of Area Agencies on Aging think that the Administration on Aging has placed sufficient emphasis in the Title IV research and demonstration programs on projects which contribute to improvement in services, and, more specifically, that there has been sufficient emphasis on helping the Older Americans Act network?

2. Does N4A have a position on "commingling" of funds. If so, does the presentation by Mr. Torrado reassure you on this issue? If not, why not?

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—Your Area Agency on Aging—

APR 1984

From The Office Of: The Executive Director

April 23, 1984

Senator Charles E. Grassley
Committee on Labor and Human Resources
Senate Office Building
Washington, DC 20510

Dear Senator Grassley:

In response to your letter dated April 10, following is my response to your two questions.

1. N4A does not believe sufficient emphasis in the Title IV research and demonstrations program has been placed on the improvement of service delivery and services under the Older American Act network. This may, however, not be solely due to the competition or funding allocation process but rather due to the dissemination process.

   It might be more accurate to say that N4A and Area Agencies have not benefitted from these projects because they are not aware of their outcomes. The network is in grave need of understanding such things as: Which service or combination of services best supports individuals in the community; How to better monitor and evaluate services for quality and efficiency; How to assist the "hard to reach" isolated elderly most in need, etc.

   We would strongly recommend a representative of Area Agencies participate in the review of proposals process and that a useful dissemination process be mandated. N4A would be willing to discuss a better process further and a possible role it could play in that process.

2. N4A does not support co-mingling of funds. It is our belief that Title IV funds of the Older Americans Act should be used specifically for identifiable age-related activities alone. The presentation by Mr. Torrado did not reassure us on this issue. Our position remains the same.

Sincerely,

William G. Orzechowski

William G. Orzechowski

WGO/jb

Services Provided: Information and Referral, Homemaker Services, Home Delivered Meals, Transportation/Escort, Domiciliary Care, Retired Senior Volunteers Program, Telephone Reassurance, Neighborhood Senior Centers, Socialization and Recreation, Employment Counseling and Placement, Protective Services, Legal Service Referral

Senator Grassley. Before I ask questions, as I have said, you have been so helpful in the four hearings we have had so far. I would like to suggest that your organizations will help us now as we are moving into this markup period to help us move this bill right along.

I think it is essential, particularly since this is going to be a relatively short congressional session because of the Presidential election year.

I have a question for both of you. Can you tell me what you folks mean by the comingling of funds?

Ms. Cain. Well, as you know, there has been money from the Administration on Aging, and also the other agencies under the Office of Human Development Services, into a pool. Our requests for proposals within certain areas have been written and have been sent out to the communities for response.

This is something that has just taken place within the last year or two. Prior to that, the Administration on Aging went ahead and wrote the requests for proposals according to the needs specifically of the aging population.

Mr. Orzechowski. That is exactly the point. There was a presentation made earlier about the review process utilized to select the successful applicants. The problem is that, in our opinion, the specific issues relative to aging are not adequately weighed and addressed.

A second issue then comes relative to the dissemination of the information. You know, it is difficult sometimes to identify what portions of those grants which are made and research projects which are conducted relate to the aged. And, specifically, then, does that information eventually get into a proper dissemination network when these funds have been comingled in such a way?

Senator Grassley. You, then, are not speaking about the comingling of funds on specific projects, right?

Ms. Cain. I am not sure.

Senator Grassley. Well, as opposed to a general approach of comingling, have you seen the comingling of funds on specific projects?

Ms. Cain. Yes. The administration has comingled the funds when they have requested proposals. There are some cross-cutting things that apply to all of the agencies, but there is nothing specifically—in other words, a pool has been developed of funds that consists of moneys from the Administration on Aging and the other agencies under the Office of Human Development Services, and that has taken place over the last couple of years.

Senator Grassley. I may have to follow on that with a written question to you.

Ms. Cain. Prior to that, the Administration on Aging developed their own requests for proposals that were strictly aging-related and not part of a pool under the Office of Human Development Services.

Senator Grassley. Well, let me say before I go on to another point that we are aware of this concern and we are going to try to address it. I had thought that when Mr. Torrado was here that we would be able to pursue with him a question on this point, but I was absent then and I was not able to have Senator Pell followup on that.

But we are aware of the concern and we will try to address that, and may have to have further communication with you on that point.

Mr. ORZECHOWSKI. An example would be the individual who discussed the case—and I have nothing to say against the particular program, about a computer software development package that will be supposedly developed to be utilized by a variety of human service provider categories.

That obviously could relate to area agencies on aging and aging services, but the approach there is to have one software package developed which will be generic enough that it can be used by various sectors of the human service network.

I would feel that in some cases that type of approach might be appropriate, but in many cases the lack of specialized attention to aging's needs has, I think, caused aging needs not to be addressed as well as they would have been in the past.

Senator GRASSLEY. Eleanor, I would like to ask you what NASUA's position is on the recommendation that N4A supports of advocating that a greater portion of the training funds go directly to the AAA's.

Ms. CAIN. Well, NASUA feels that the training funds should continue to go to the State units on aging. I think that you will find in probably most States that a great deal of that money trickles down to the area agencies within the State, and the area agencies do have an opportunity to write a training plan to train their staff and people within their specific geographic location.

But NASUA does feel that the money should continue to come to the State units on aging; that there is a great deal of training that should be done on a State level that requires the attendance of both State staff and area agency staff; and that the State unit on aging is the agency where that money should be funneled to.

Senator GRASSLEY. Did you want to comment on that?

Mr. ORZECHOWSKI. I may have some clarification. Obviously, there are in many cases, of appropriate types of training, that the State units should conduct or arrange to have provided.

On the other hand, I think it can be perceived as a developmental process. Many of the activities the States have been utilizing training funds for at the State level are activities that have developed to the point now where the area agencies are the direct providers of service or are themselves arranging to have the service provided through other entities and organizations.

I think if you look at it in a developmental perspective, at some point the area agency has to have adequate funds to train its own staff, the subcontractor's staff, its volunteers, and so on.

So I think a key term there is that when you are looking at this in a developmental fashion, particularly relative to some of these critical priority types of services, I feel that area agencies and their subcontractors and their volunteers have to at some point have adequate training funds, if not necessarily early on in the process while certain types of generic developments and training are being conducted at the State level, at some point further down the road.

Senator **Grassley**. Bill, does your association think that the Administration on Aging has placed sufficient emphasis upon title IV research and demonstration projects in regard to whether or not this contributes to the improvement in services, and more specifically whether there has been sufficient emphasis upon helping the Older Americans Act network?

Mr. **Orzechowski**. That is a complicated question; it might be time consuming. We would be happy to follow up my remarks with some written response. I guess maybe the way, without trying to be——

Senator **Grassley**. Would it be easier for you if you just submitted in writing your response?

Mr. **Orzechowski**. I think it would.

Senator **Grassley**. OK.

Mr. **Orzechowski**. Given how things have occurred over the last couple of years, I am always leery when the Administration uses terms such as "wanting greater flexibility" or wanting to "consolidate responsibilities" or "be given greater administrative discretion," whether that be at this level or at the State level.

The results relative to the resources actually reaching the local level, whether it be for training, whether it be the dissemination of the information collected by model projects funded at higher level—the results have been, I think, less resources than otherwise would have reached the local level. So I think it is a rather complicated issue to address.

Senator **Grassley**. Then we will wait for your answer in writing. We would appreciate that in about 15 days, please.

My last question is to both of you. I would like to have your comments on whether long-term care gerontological centers have been helpful to you and whether or not you endorse the program. Will both of you respond to that?

Ms. **Cain**. As you know, the grants were awarded several years ago to a university or college in each region that was designated as a long-term care gerontology center. At that time, NASUA and also the various States had an opportunity to review the contract as it was awarded.

It was definitely too cumbersome and too broad a mission to think that any center could go ahead and achieve all of the objectives that were in that grant. It is my understanding that since then, especially during this past year, the Administration on Aging has requested that the centers visit with the States to develop one or two priorities within each State so that they could be of more specific assistance in certain areas.

This has happened in Delaware. In fact, the two areas that we have specified are the areas of adult protective services, and also mental health and the aging. Since Delaware does not have a college or university that has a long-term care gerontology center or any type of center on aging, nor do we award any certificates or degrees in gerontology, Temple University, which is a long-term care center in region III, has been very helpful to me in those two particular areas.

Senator **Grassley**. Bill?

Mr. **Orzechowski**. As I indicated in my written testimony, from the area agencies' perspective nationwide, the degree to which the centers have been helpful to this point has varied. I think they have varied significantly. That is the feeling that I get from area agencies across the country.

As I pointed out, they previously focused on what I would consider academic and conceptual long-term care models, with limited efforts at practical applications to date. But I mentioned that they hold promise for the future.

Exactly as Ms. Cain indicated, I do see a tendency to try and focus and prioritize with the area agencies and the State units being involved. As she indicated, I think there has been the very best of intentions, but too broad a definition of purpose and objectives was initially the case, and just diffused a great deal of the impact.

Senator **Grassley**. That is my last question. I want to thank you once again, and every other witness and everybody who attended, for cooperation in every respect, particularly considering the fact that so many of us had to be in and out. We look forward to working with you all.

[Additional material submitted for the record follows:]

Written Testimony of
Eugene S. Callender
Director, New York State Office for the Aging
submitted for inclusion in the hearing record of the
Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources
February 28, 1984, Hearing on Title IV of the Older Americans Act

Although I am pleased to have the opportunity to submit recommendations for the reauthorization of Title IV of the Older Americans Act, I must say at the outset that if the Administration's budget request were to be accepted for these vital programs, then the content of the Act would be largely irrelevant. No matter how good the reauthorization of Title IV may be in programmatic terms, it will be meaningless if no funding is made available.

The Administration has proposed reducing the Title IV program from its current level of $22.175 million for Federal Fiscal Year 1984 to only $5 million for FFY 1985. The Administration has proposed these drastic cuts in prior years, and Congress has wisely rejected them. Although appropriations issues are beyond the reach of an authorization bill, I hope the committee report on the Older Americans Act reauthorization will document in the strongest possible terms the need for increases, not decreases, in the vital training programs under Title IV.

In New York State, the State Education and Training Program under Title IV-A of the Older Americans Act is an important component of our aging services management system. The reauthorization, together with appropriations decisions, should maintain the integrity of this program, which has a proven history of performance. Through the training and education initiatives that are funded under Title IV-A, we are successfully building the capacity of aging network personnel to effectively and efficiently meet the complex needs of our older population.

In building a sound management foundation for the service programs of the Older Americans Act, Title IV-A funds constitute the primary source for training of local program administrators in the necessary methods for assessing, planning, and implementing services to meet the needs of elderly throughout the country. The potential effects of the type of funding reduction proposed by the Administration would be devastating.

Can the Administration truly claim to be meeting the needs of the most needy when it would be contributing to the skill shortage in the field of aging? Can we realistically expect Area Agency on Aging directors to be able to competently discharge their responsibilities if we are unable to provide them with the necessary training and technical assistance? Would it be effective and programmatically advantageous to have a cook or dietician in the nutrition program who is unfamiliar with the operating procedures of the program? Can an information-and- referral system of an Area Agency fulfill its role as the link between an elderly person in desparate need of a service and a potential service provider if the I&R workers do not receive ongoing training and technical assistance on which resources are available and how best to use them?

Though the field of aging is relatively new, it is complex. The needs in this area are increasing rapidly while resources shrink. The pressures on staff to "do more with less" are mounting. The requirements which must be met to deliver quality services while soliciting funding from numerous funding streams have become more and more complex. Thus the aging network is facing the need to train new staff and re-train current staff to insure their effectivenss. Without such training, the "burn-out" phenomenon is a serious danger that would adversely affect our elderly service recipients.

Faced with these vital needs yet threatened with further funding reductions, the State Education and Training Grant program under Title IV is at a critical turning point. Because of the proven successes of this program in improving the skills of aging network personnel, I urge that the reauthorization bill earmark at least 25% of each year's Title IV apprupriations for the State Education and Training Grant program under Title IV-A. Of all the worthwhile programs funded under Title IV, the State Education and Training Grants have the closest tie to the quality of services offered under Title III, and I urge this Subcommittee to protect this link from potential shifts in priorities within the Department of Health and Human Services.

Because many of the other Title IV programs can be effectively linked with aging network services, I would like to highlight two projects which the New York State Office for the Aging has worked closely with over the past five years: Career Preparation Programs and the Minority Management Training Program.

As you know, the Career Preparation Program is designed to encourage academic institutions to provide professional and college-level training and education to people entering the aging services field, to service providers needing instruction on the special needs of the elderly, and to individuals working in the network who seek continuing education in gerontology and related areas. Approximately 230 colleges and universities throughout the United States have been involved, and at least 30,000 students have received formal certificates or degrees in gerontology. These numbers are impressive in view of the relatively short time span during which the program has been operating, the relatively small amounts of funds available to individuals seeking to enter the field of gerontology, and the severe cutbacks imposed on the Career Preparation Program in recent years.

The impact of these funding reductions has been direct, and quite severe. According to the Association of Gerontology in Higher Education:

> In the fall of 1981 a study was conducted of the 51 schools which had received Title IV training support but had lost that funding by 1980. Twenty-five percent had discontinued their gerontology programs, with an additional five percent considering the possibility of discontinuing the program at the end of the 1981-82 academic year. Of the remaining 36 institutions, less than 10 percent had been able to maintain the level of activities that had been possible under AoA support. Between 10-15 percent had been able to find temporary sources of outside support to continue the previously-supported AoA programs. In short, the gerontological instructional programs of as many as 80 percent of the institutions whose AoA support was discontinued prior to 1980 have either been terminated or substantially reduced.

This situation clearly projects a decreased capacity to effectively address the needs of our growing elderly population. When we look to the future, we see more elderly but apparently fewer people trained in gerontology to help address their needs.

From the vantage point of a State Office for the Aging, I would agree with early detractors of the Career Preparation Program, that initial programs developed by the academic community needed to move closer to meeting the practical training and educational needs of those individuals with practical experience and everyday responsibilities for serving older people through the aging network. This objective has been furthered in New York State through the cooperative efforts of the State Office for the Aging and Career Preparation Programs in various institutions throughout the State. New York has been fortunate in having the commitment of outstanding institutions such as Columbia University, Syracuse University, Fordham University, the Brookdale Center on Aging, and the North Country Community College, among others, with outstanding academic credentials and strong sensibilities to the practical applications of academic study. Because of this commitment, the gerontological programs they have developed are capable of meeting the needs of both the theoretician and the practicioner.

Because the aging network must make special efforts to reach minority elderly and others in the greatest need, I urge this Subcommittee to indicate its strong support for the Minority Management Training Program. This program was created to provide minority individuals with career development opportunities in the field of aging and gerontology. Specifically, the program places selected minority professionals in administratively responsible positions with a view toward permanent job placement within the aging network. Over the last three years, the New York State Office for the Aging has benefited from the skills and dedication of four very talented minority interns.

The Minority Management Training Program, which is a cooperative effort by the four national minority aging organizations (Asociacion Nacional Pro Personas Mayores, National Caucus and Center on Black Aged, National Indian Council on Aging, and National Pacific/Asian Resources Center on Aging), reflects a recognition that a substantial increase in the currently very small numbers of minorities in career and professional positions within the aging network is essential to improvements in the network's ability to reach and serve minority elderly. An increase in minority aging services professionals will improve understanding of cultural norms and service considerations that now retard network efforts to increase minority participation. Yet due to funding cutbacks, the four major minority sponsors of the Minority Management Training Program have had to curtail their efforts over the past two years. Because of the extremely positive experiences which the New York State Office for the Aging has had with this program over the years, I urge the Subcommittee to include strong support for this program in its committee report on the Older Americans Act reauthorization.

The Administration's proposed reductions in Title IV programs cannot reflect any rationale assessment either of program effectiveness or of the need for these training, research, and discretionary programs. Rather, the Administration budget proposal neglects the need for investments in human capital to help the Nation prepare for the needs of the growing elderly population. I urge this Subcommittee to make every effort to prevent the adoption of these short-sighted cutbacks.

Because the Senate version of the reauthorization has not yet been introduced, I would like to comment briefly on some specific proposals to amend Title IV which are contained in H.R. 4785, the companion House bill. H.R. 4785 contains an excellent set of Title IV provisions for consideration by this Subcommittee as well as your House counterpart.

For example, I was pleased to note that H.R. 4785 provides for elevating the Commissioner on Aging (and the Administration on Aging) to an Assistant Secretary on Aging (and an Office on Aging) [§ 103(2) of the bill, among others]. The current structure, with the Commissioner reporting to an Assistant Secretary for Human Development Services, has simply not worked. Especially where the Administration has discretion in awarding grants, as under Title IV, aging concerns have been subsumed under other goals--often worthwhile goals, to be sure, but goals directed towards population groups other than the elderly.

Thus the proposal for an Assistant Secretary on Aging is a necessary one, as are the provisions specifying that the Assistant Secretary must remain directly in charge of administering Title IV funds [§ 412], with strengthened reports providing sufficient information to assure that discretionary projects address the priority purposes of the Older Americans Act, and forbidding combining Title IV funds with those under other programs to create single discretionary awards [§ 410(b)(3)]. I also hope that appropriate committee reports and other legislative history will highlight congressional concern over continuing violations of the existing requirement of section 201 of the Older Americans Act, forbidding delegation of authority to staff outside of the Administration on Aging.

I welcome the provisions of H.R. 4785 which would deconsolidate Title IV and specify priorities for Title IV grants, as well as those including Alzheimer's and related disease and family support initiatives among priority demonstration projects. Specific advocacy assistance grants to States for legal services and ombudsman development should be strengthened and adequately funded.

As I noted at the beginning of my testimony, the biggest issue regarding Title IV--provision of adequate funding--cannot be resolved through the reauthorization process. With substantially reduced State Education and Training grants since fiscal 1981, State units' ability to enhance the capacity of Area Agencies and the rest of the aging network has been lessened. The Administration's budget request for Federal Fiscal Year 1985, if enacted, would decimate these training efforts. In addition to providing adequate appropriations, Congress should mandate that the Administration on Aging award at least 25% of Title IV appropriations for State Education and Training grants. Initial AoA proposals for reducing these allotments still further would have severely harmed the aging network; these proposals should not be allowed to resurface.

In setting authorization levels for Title IV and in making recommendations on appropriations, I hope that this Subcommittee will go beyond the need to restore funding cuts which have been imposed or proposed in recent years. Rather, Congress should recognize the major need and projected demand for expanded research, training, and demonstration programs to help prepare the Nation for our increasing elderly population while meeting the needs of current elderly more effectively.

Testimony Regarding
S.2221--Older Americans Act (Public Law 89-73)

Before the
LABOR AND HUMAN RESOURCES AGING SUBCOMMITTEE
UNITED STATES SENATE
February 28, 1984

Presented by
Marlene J. Hoglund

1776 Harvard
Wichita, Kansas 67208
Telephone (316)685-5285

Distinguished Chair and members of the Labor and Human Resources Aging Subcommittee:

I am Marlene J. Hoglund, gerontology graduate student working in the Mullikin Resource Center, a project of the Gerontology Program at Wichita State University.

I would like to thank you for this opportunity to state my opinions regarding reauthorization of the Older Americans Act(Public Law 89-73).

Based on my experiences in working in the Mullikin Resource Center and in the graduate program, I strongly support specifically the continuation of funding of projects begun previously under Title IV, Part A, Section 412 which focuses on Multidisciplinary Centers of Gerontology. Projects, such as the Mullikin Resource Center, directly help to fulfill the following three responsibilities of Multidisciplinary Centers of Gerontology:

1. They act as clearinghouses for collecting and disseminating materials developed in the field of aging in areas of education and training;

2. They advance education and training by recruiting persons for careers in aging;

3. They facilitate model materials development and building of capacity.

The Mullikin Resource Center for Gerontology

The Resource Center began in 1978 as a collection of free materials on aging. Nearly 6,000 documents--books, government documents, papers read at professional meetings, university publications, technical bibliographies--in more than 70 subject areas relating to aging currently comprise the Center's holdings. Most of these have been obtained free-of-charge or inexpensively through Title IV grant monies. The Resource Center began as an instructional support service to assist faculty and students acquire current and new

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information in the field of aging. In 1983, more than 1950 documents were checked out by 48 faculty members and 157 students.

The MRC has branched out to provide outreach to service planners and providers currently working in the field of aging and to the media and public-at-large. Seventy-five community members including service providers from Area Agencies on Aging, local senior centers, a hospital rehabilitation unit and the regional medical school checked out 425 documents in 1983.

The Resource Center has become an invaluable link in the aging network, not only in the university community and in the city-at-large, but also to universities and cities in surrounding communities and states, active within the interlibrary loan system. Materials have been sent to persons in cities including Mcpherson, Salina, Ark City, Coffeyville and in states including Missouri and Washington. Operating with student staff, the Resource Center has become a project that could be implemented in small towns, colleges and rural areas interested in enhancing the aging network. Resource centers have been developed in a local hospital and an Area Agency on Aging, thus making information more accessible to service providers.

Resource Center Contributions to Multidisciplinary Centers of Gerontology

It is well established that Multidisciplinary Centers of Gerontology train professionals with a broad base of interdisciplinary knowledge. Library and clinical research must be available to those studying to be professionals in the field of aging to ensure the quality of their training. Projects such as the Mullikin Resource Center(MRC) provide access to such library research material often not found in the traditional library setting. If such material on aging is found in the library, it is scattered throughout, shelved within each respective discipline. This makes research efforts laborious, if not haphazard. The MRC is a centralized clearinghouse designed to collect and disseminate materials developed in the field of aging. Documents collected by the MRC are often in forms not manageable by the traditional library. Papers presented at gerontological meetings are obtained before publication, often a two-year lag. This makes available new information and research efforts in the field of aging. Two faculty members have relied on the Center's holdings in constructing their research proposal on older diabetics which is to be submitted this year.

Projects such as the Resource Center become not only instructional services, but also become outreach tools to practicing professionals, the media and the community at large. This tool helps to "bridge gaps" and link resources within the aging network. The local newspaper published a series of articles on health care and aging using Resource Center material. Background information on health was obtained from the Resource Center by a regional medical school conducting a health needs survey which was published in a local paper. The manager of a soon-to-be-built retirement community was able to correct a number of items in the building design before they were built by referring to several of our books on environmental design. Materials have been used extensively in the planning of a new local day care center to open this May. Center materials have often been used by the gerontologist employed at a local hospital rehabilitation unit in planning programs for stroke victims and their families.

Projects such as the MRC advance education and training within multidisciplinary centers of gerontology by helping to recruit students at the graduate level. Tuition reduction and assistantships are awarded to graduate students who then work in the MRC to acquire, catalog, publicize and disseminate the center's holdings. Only through continued funding efforts can

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these projects remain.

Projects such as MRC function as models in materials-development and capacity-building. MRC acts to supplement the traditional library, not to compete with it or to replace it. It performs unique functions in acquiring materials not always available in a library. Requests from other universities and community agencies have been made to the MRC for assistance in organizing and developing document collection. A hospital in St. Louis and another university in Kansas with a center on aging have recently requested such information. With continued funding, established projects similar to the MRC, can operate to enhance the aging network in other communities.

In conclusion, projects similar to the MRC are granted only initial funding under the current Title IV guidelines. Only continued financial support for these projects will allow them to continue to function as the key components of the aging network that they are. I urge your reauthorization of these established projects covered under The Older Americans Act, Title IV, Sec. 412.

Thank you.

American
Psychological
Association

March 1984

APR 1 . 1984

MEMORANDUM

TO: Interested Parties

FROM: Alan Kraut
Larry Rickards

RE: Testimony on Training and Research Under the Older Americans Act

The American Psychological Association (APA) and the Association for the Advancement of Psychology (AAP) submitted testimony to the Senate Committee on Labor and Human Resources Subcommittee on Aging to delineate concerns regarding the research and training provisions in Title IV of the Older Americans Act. Severe reductions in the funding of the Administration on Aging's discretionary program under Title IV have damaged programs of particular interest to psychology, and may serve to dilute the role psychology can play in meeting the needs of the aged.

The APA/AAP testimony urged Congress to enact 1984 amendments to Title IV which will strengthen the training and research opportunities for psychology and for other disciplines working in the area of aging and mental health.

Attachment

1200 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

American
Psychological
Association

TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

to the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

Hearing on Title IV of the

Older Americans Act

February 28, 1984

1200 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

The American Psychological Association (APA) and the Association for the Advancement of Psychology (AAP) are pleased to present testimony to the Senate Labor and Human Resources Subcommittee on Aging hearing on Title IV of the Older Americans Act.

The American Psychological Association, representing over 72,000 members, is the major organisation of psychologists in the United States. The Association is active in promoting responsive concern by the profession on a variety of social and public policy issues; disseminating psychological knowledge to enhance and increase human progress and well-being; developing standards of education, ethical and conduct and professional practice; and promoting research by working to improve methods and conditions.

AAP is an autonomous advocacy organization which was established to help represent the interests of psychology in the public policy arena.

APA was honored to present testimony in conjunction with the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, the American Nurses Association, the American Psychiatric Association, and the National Association of Social Workers at the Subcommittee hearing on Long Term Care and the Older Americans Act. That testimony documents our association's concerns regarding the mental health services provisions of the Older Americans Act.

In submitting this testimony, we wish to deliniate APA/AAP's concerns regarding the research and training provisions in Title IV of the Act, as they relate to the role which psychology can play in meeting the needs of older Americans.

As the Subcommittee is no doubt aware, the Older Americans Act Title IV program has sustained severe reductions in both funding and Administration support over the past three years. Although we recognize that we have entered an era of fiscal restraint, it is this Association's view that cuts in the Administration on Aging (AoA) discretionary program have been disproportionately severe. Since 1980, the Older American's Act Title IV budget has been reduced by nearly 60 percent. These budget cuts have seriously damaged programs of particular interest to psychology, such as the Career Preparation Program and the Research and Demonstration Program

It is our belief that these reductions may stem in part from a misinterpretation of the 1981 Older Americans Act Amendments. The 1981 amendments consolidated and streamlined Title IV, which had previously contained specific provisions for each of the Title IV discretionary programs. Although Congress in enacting the 1981 amendments did not intend to dilute these programs, the Administration clearly interpreted this action as an opportunity to undercut the array of discretionary programs. It is, therefore, apparent that there is a need to reinforce Congressional support of these programs.

The reduction in AoA training and research programs has come at an unfortunate time for the field of psychology, which has only recently begun to develop graduate level programs in gerontology. This burgeoning interest in the psychology of aging is, in part, a result of APA sponsorship of the White House Conference on Aging Mini Conference on the Mental Health of Older Americans and a recent APA Conference on Training Psychologists for Work in Aging. As a result of recommendations and suggestions generated by these conferences, APA has undertaken to publish a major new journal, titled Psychology and Aging (due for publication in 1985), and has featured a series of articles on aging in the APA primary journal The American Psychologist. The Association is currently considering the publication of a series of curriculum modules on aging to be used in a range of undergraduate psychology courses. APA has also published two major books, Aging in the 1980's - Psychological Issues, edited by Leonard W. Poon, Ph.D., which outlines the major research issues in the field, and Psychology and the Older Adult: Challenge for Training in the 1980's, edited by John F. Santos, Ph.D. and Gary R. VandenBos, Ph.D., which outlines modules for the training of psychologists in aging. We have also been actively involved in supporting the budget and programs of the National Institute of Aging particularly as they relate to basic behavioral and social issues in aging.

While these national level activites are clearly significant, and demonstrate psychology's sustained commitment to gerontology, they can not replace the impact of field-based research and training programs in the development of a knowledge base and development of models of care for the aged. Psychology has much to offer the interdisciplinary arena of gerontology. Psychologists are trained to undertake behavioral and other research, to evaluate service systems, to provide training, and to provide clinical services. Many of these skills are needed, and can be effectively integrated in the programs and service systems funded by the Older Americans Act. Unfortunately, however, the cadre of psychologists who work in the field of aging is still quite small. There is clearly a need for leadership on the part of the Congress and the Administration to stimulate further research and training activities in which psychology can participate.

The 1984 Older Americans Act amendments offer a renewed opportunity to adjust these directions, not just for psychology but for the general field of aging. The American Psychological Association and the Association for the Advancement of Psychology call upon Congress to enact 1984 amendments to Title IV which will strengthen the training and research opportunities for psychology and for other disciplines working in the area of aging and mental health.

We have reviewed the Title IV amendments proposed by the Association for Gerontontology in Higher Education (AGHE). In general, the American Psychological Association and the Association for the Advancement of Psychology support and endorse the AGHE position on the training and education and research sections of the Act. However, we urge that in considerating the AGHE proposal the Subcommittee should include reference to mental health as well as to health care generally. We believe that this addition will both clarify and strengthen the AGHE position, with which we on concur in all other respects.

In addition, we join with the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging, the American Psychiatric Association, the American Nurses' Association and the National Association of Social Workers in support of the establishment of a separate section under Title IV on "Special Population Training" to train Title III service providers and nursing home care providers to meet the special needs of the mentally impaired elderly.

The American Psychological Association and the Association for the Advancement of Psychology stand ready to assist the subcommittee in their efforts to reauthorize the Older Americans Act. We appreciate the opportunity to put forward our views on this important legislation.

AGHE
Association for Gerontology in Higher Education
600 Maryland Avenue, S.W. • West Wing 204 • Washington, D.C. 20024
(202) 484-7505

TESTIMONY
OF
ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

BY

PAUL L. SHEPHERD
UNIVERSITY OF MARYLAND
PUBLIC POLICY COMMITTEE, AGHE

ON REAUTHORIZATION OF THE OLDER AMERICANS ACT
TITLE IV

SUBMITTED TO
A HEARING OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING

FEBRUARY 26, 1984

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Chairman Grassley and other distinguished members of this sub-committee. The Association for Gerontology in Higher Education appreciates the opportunity to submit written testimony on behalf of the strengthening of Title IV in the reauthorization of the Older Americans Act. I am Paul Shepherd, Public Policy Chair of the Association. I submit this testimony not only in this role, but also as a former Director of Planning and Evaluation of a five-county rural area agency on aging, where I became acutely aware of the need for basic information on gerontology and gerontological practice and for adequately trained personnel to effectively and efficiently design and deliver programs for older Americans. The need for trained personnel is particularly critical if the social intervention strategies that are put into place are to result in maintaining or improving the independence and dignity of our elders rather than to strip them of their dignity and to promote dependency. The programs that are designed and implemented for older adults will be only as effective as the staff that implements them. I am reminded of one of the nutrition project managers who worked for our area agency when I joined the staff, and who would carry a whistle and clap her hands to make the "old folks" stand, somewhat at attention, when I visited her center. She was a prime example of how the goals of a potentially valuable program can be undermined by ill-trained staff and how the myth of uselessness of the aged is maintained.

Our discussions of the future of Title IV should not be viewed as extraneous to service delivery to older adults, but as an integral part of the service delivery network that assures that the goals of programs for older adults are accomplished. We are here, therefore, to discuss the future effectiveness of the very service programs that we all hold dear when we discuss the future of Title IV.

Congress recognized from the outset the importance of education, training, research, and demonstration projects in the development of programs for older adults. This was reflected in the 1966 appropriations for the Older Americans Act, when 23% of the total OAA budget went to support these efforts. As funding increased, Title IV appropriations kept pace such that in 1972 22.3% of the OAA budget was allocated for these purposes. The members of AGHE and our coalition partners support the notion of simple reauthorization of the Older Americans Act. However, the last three years have witnessed dramatic changes in Title IV which we feel need correction. Therefore, we are recommending several adjustments designed to restore strength and clarity to Title IV.

In my role as Public Policy Chair of AGHE, I and other representatives of this Association have been actively seeking to strengthen the language of Title IV to insure the future development of relevant information and the availability of trained,sensitive personnel to staff the aging network. Our efforts have been directed toward maintaining the independence of the Older Americans Act programs from other OHDS programs and the integrity of the various programs within Title IV. We have developed a set of recommendations that we feel would result in improved quality of life for America's elders by insuring that programs for the aged are planned and administered in a manner that promotes the dignity of old age. I would like to explain our recommendations and, just as important, the process that produced them, after which I would like to address some of the questions which you kindly provided.

Last summer a bipartisan task force consisting of representatives of education, practice and the private sector was formed to make recommendations on the reauthorization of the Older Americans Act. Members of the task force included

Paul Kerscher, AARP, James Sykes, Wisconsin Cheeseman, Carroll Estes, University of California-San Francisco, Neal Bellos, Syracuse University, Carter Osterbind, University of Florida, Tom Hickey, University of Michigan, and myself. Recommendations were formulated on each section of Title IV and submitted to the AGHE Executive Committee, which approved them unanimously. These recommendations then became the basis for deliberations with representatives of many national aging organizations. A coalition of these organizations was formed, including the National Center/Caucus on the Black Aged, the Asociacion Nacional Pro Personas Mayores, the National Pacific/American Resource Center on Aging, the American Association of Retired Persons, the National Council on the Aging, the National Senior Citizens Law Center, the National Farmers Union, the American Association of Homes for the Aged, and AGHE. Organizations later endorsing the principles drafted by this coalition include the Gerontological Society of America, the National Association of State Units on Aging, the National Association of Area Agencies on Aging, and the National Council of Senior Citizens. Collectively these organizations represent more than 19 million older adults, 200 institutions of higher education, and numerous practitioners and educators in the field of aging. This coalition drafted a set of principles and eventually, at the urging of Congressional staff, statutory language. This language was distributed to members of the Leadership Council of Aging Organizations and to Congressional staff, many of whom held meetings with the coalition to discuss the proposals. I share this process with you to demonstrate that the recommendations I am about to make represent the concensus of a wide range of organizations and individuals.

We have organized our recommendations into six principles. These are:

1. Three-year reauthorization.
2. Simple reauthorization with corrective changes to Title IV.

3. Deconsolidation of Title IV.
4. Prohibition of co-mingling of Title IV programs with other OHDS programs.
5. Increased authorization levels.
6. Improved reporting requirements.

The first principle is self-explanatory, as is the second. The third through sixth principles constitute the "corrective changes" that we request in our second principle. I shall focus upon these latter four principles.

The first of these four principles is the deconsolidation of Title IV. We recommend that separate program categories be restored with specific authorization levels for each. The purpose of each program category should be clearly stated and the role of the title to the planning and provision of services clarified. A general statement of purpose should be added to Title IV to accomplish this latter function. The purpose statement should clarify that Title IV is established for the purpose of training personnel to work in programs and to pursue research in the field of aging rather than to duplicate the purposes of Title V. It should further clarify that training and educational efforts include both short-term in-service training and continuing education for personnel already in the field and long-term educational programs to prepare people to work in the field, and it should emphasize both quality (building upon existing programs and knowledge) and innovation. Long-term goals need to be established for education and training programs to insure adequate personnel in future years to work with older adults. In this regard the role of academic institutions as national resources for gerontolgoical education, training and research should be recognized and supported. The special education and training needs of minorities and rural residents should be emphasized, and programs established to meet their needs.

The deconsolidation of Title IV should include the restoration or retention of the following:

1. Research: A general purpose statement should be included to specify long-term research goals for the Administration on Aging. This purpose statement should emphasize that Title IV funding is available both for "investigator-initiated" research and "directed" research from AoA. A commitment to both quality and innovation should also be stressed.

2. Section 422. Demonstrations: Section 422 should be retained, including the emphasis on certain target groups (e.g., serving the rural elderly and improving services for the minority and low-income aged). The cooperative roles played by academic institutions and service providers should be emphasized.

3. Special Projects in Long-Term Care: The current section 423 should be clarified to state that it is a goal to have an AoA-funded long-term care gerontology center in every Federal region.

4. Special Demonstration Projects on Legal Services for Older Americans.

5. Multidisciplinary Centers of Gerontology: Section 412 should make it clear that national policy centers are included within "gerontological centers of special emphasis."

This list of categories is not meant to be all-inclusive. Rather, it is illustrative of the categorical breakdowns of Title IV that we feel would strengthen the Act. A complete breakdown is included in our draft Title IV language previously submitted to your staff.

Our fourth principle is to prohibit the comingling of OAA Title IV funds with other programs of OHDS. We feel that Title IV funds should be used specifically for identifiable aging related activities. Current practices result in lack of clarity in the use of Title IV funds and a usurption of the powers of the Commissioner by the Office of Human Development Services. This point was clearly illustrated recently when a high-level AoA official instructed reviewers of proposals in aging to score proposals they felt were worthy high "because aging proposals are in competition with other administrations of OHDS." This practice not only flies in the face of the law, but it results in further fragmentation of our society by pitting youth, the handicapped, and the aged against each other. The long-term effects can only be to further disintegrate the cohesiveness of our society.

Our fifth principle is to restore authorization levels to more realistic levels. No other title of the Older Americans Act has suffered as much over the past three years as has Title IV. Authorizations have been reduced by 59% from FY'80 to FY'84, from $54.3 million to $22.2 million. The Administration proposal of $5 million for FY'85 represents a 92% decrease from FY'80. The important functions of Title IV simply cannot be carried on without adequate financial support. The irony of the administration's action is that it is likely that Title IV funds, more than funds from any of the other titles, result in the establishment of programs that are carried on eventually by local funds. The Institute for Gerontological Practice at the University of Maryland, of which I am the Director, is an example of this. Originally funded by an AoA grant, the program has grown and become an institutionalized component of the University's continuing education programs. Gerontology will not develop as a social science on its own. The institutional resources and commitment are simply lacking in these times of decreasing enrollments and shrinking budgets.

Federal support of gerontological education, training, and research has had a significant multiplier effect. As a result of federal support there has evolved a cooperative effort between the private sector and local, state, and federal governments to support gerontological research and education. Again, I would refer you to the Institute for Gerontological Practice at the University of Maryland. Over its four and one-half years of existance we have received directly or indirectly support from proprietary nursing home firms, private housing management firms, several state governments, area agencies, and private donors. This Institute would not exist today had there not been an initial investment by the federal government.

Increased authorizations for Title IV are necessary if we are to continue providing quality programs for older adults and if we are to keep in step with the rapidly changing older adult population. Rural service planners and providers will be particularly hard hit, as they often depend exclusively upon Title IV funded research and training for up-to-date information on service designed delivery. The staff of rural area agencies generally possess lower levels of formal education than their urban counterparts, and they have the least access to educational opportunities. If the authorization levels for Title IV programs are not restored, gerontological training and education for these groups will be virtually eliminated. Rural demonstration projects funded under Title IV have produced significant innovations in addressing the unique circumstances of being older in rural America. These demonstrations would not exist if it were not for Title IV of the Older Americans Act, inasmuch as most rural areas lack the economic base to fund such activities.

Our last principle relates to strengthening the reporting requirements of the Commissioner in relation to Title IV. We feel strongly that many of the questions raised by members of Congress would be answered if they were regularly provided a report on activities funded through Title IV. Therefore, we propose that the Commissioner be required to submit a detailed annual report to Congress describing programs funded under Title IV, including the results of each.

Finally, we urge your committee to support Congressman Ike Andrews' bill (H.R. 4785) to reauthorize the Older Americans Act. This bill, from the perspective of the groups in the Title IV coalition, has the following strengths:

(1) It calls for a three-year reauthorization of the OAA.

(2) It elevates the position of the Commissioner on Aging to Assistant Secretary of OHDS.

(3) It calls for an increase in authorization levels for Title IV--5% over current levels. While we support higher authorization levels, we are encouraged that this bill does not support further dramatic reductions in Title IV authorizations.

(4) It includes purpose statements for the Education and Training Part and for the Research and Demonstration Part, along with more precise language about the types of programs to be funded.

(5) It calls for increased reporting requirements on the part of the Commissioner on Aging for Title IV programs.

We are asking both the House and Senate authorizing committees to make the following additional changes to Title IV. These changes are not, at present, incorporated into H.R. 4785:

(1) Addan overall purpose statement for Title IV to clarify for the Administration on Aging the role of these programs in the Act.

(2) Reinstate separate parts for (a) Research and Development and (b) Demonstrations and Special Activities. Those two functions are

discrete and should not be combined, as they were in the 1981 amendments.

(3) Consider having separate authorizations for each Part of Title IV (Education and Training, Research and Development, Demonstrations and Special Activities) to protect against the virtual elimination of funding by the Administration on Aging of any one of these vital functions.

(4) Prohibit the commingling of AoA's discretionary funds with those of OHDS. While this prohibition would allow for cooperative projects with non-AoA federal programs, it would assure that Title IV discretionary funds are used for identifiable aging-related activities which are under the jurisdiction of the Commissioner.

(5) Re-introduce a statement about the importance of minority training, such as represented by the 1978 Cranston Amendment (OAA, Sec. 404, (6), 1978 amendments).

(6) Specify the requirement that at least one long-term care gerontology center be continued in each federal region.

(7) Incorporate long-range education and training goals for Title IV, such as those recommended by the 1981 White House Conference on Aging.

At the request of the staff of the House and Senate authorizing committees, the Title IV coalition described above drafted statutory language which accomplishes the principles outlined in this testimony. We have held a series of meetings during the past several months with many of your staff and have shared these principles and statutory language with them. If you have any questions about our recommendations or would like copies of that language, please contact this Association.

In conclusion, we are in support of a simple reauthorization of the Older Americans Act, but would recommend some clarifying and strengthening language for Title IV. This Associaton stands ready to provide whatever guidance you feel is appropriate as this reauthorization progresses. We thank you for the opportunity to participate in this important process.

STATEMENT

OF

JOHN M. CORNMAN, EXECUTIVE DIRECTOR

THE GERONTOLOGICAL SOCIETY OF AMERICA

PRESENTED TO

SUBCOMMITTEE ON HUMAN SERVICES

SELECT COMMITTEE ON AGING

UNITED STATES HOUSE OF REPRESENTATIVES

ADDRESSING THE

1984 REAUTHORIZATION OF THE OLDER AMERICANS ACT

MARCH, 1984

Mr. Chairman, The Gerontological Society of America welcomes the opportunity to present its view on reauthorization of the Older Americans Act. Given the demographic changes facing our nation, the direction Congress gives to the Act in this reauthorization process will significantly affect how successful we are in meeting the challenges of the future. Because of the importance of the Act, the Council of the Gerontological Society, for the first time in several years, endorsed a position statement on all the Act's titles, as well as a more detailed section of Title IV, which has been the Society's principal concern. Let me begin with a discussion of Title IV and then turn to the broader statement.

The magnitude of change resulting from the aging of the nation's population is clear. The number of residents 65 years and over is expected to increase from 25.5 million in 1980 to 64.3 million by 2030. By the year 2010, the number of persons 80 years and over will double to 10 million. It is also clear that these changes will require responses from the public sector. However, because an aging society is a new phenomenon for western society, there is little experience to guide future actions. Congress and other decision makers, then, need information about demographic, economic, health, and other trends among the elderly, the kinds and levels of service needs the trends will create, and the kinds and numbers of personnel required to meet the needs. Title IV activities - research, demonstrations, education and training - take on increased importance in meeting this challenge.

Not surprisingly, as the national professional organization of researchers, educators, and practitioners in aging, the Gerontological Society has had a continuing and deep interest in the research, education, and demonstration programs authorized by Title IV. By the same token, the Society has been concerned by the dwindling financial support for Title IV and the recent attempts of the executive branch, in essence, to eliminate funding for all Title IV programs. Certainly, the Society appreciates greatly the actions of Congress which have provided sufficient funds to maintain a useful if significantly diminished level of activity. However, I must admit that I find the declining support for Title IV appropriations somewhat puzzling in light of the facts that:

- Title IV is the principal source of federal support for research and demonstration projects to determine need for and test non-medical service delivery programs for the elderly;
- Title IV is the principal source of federal support for the education of service delivery trainers and practitioners;
- In the years that federal appropriations for Title IV have fallen from a high of $54.3 million to a low of $22.2 million, the elderly population has been growing steadily with a corresponding increase in need for flexible housing arrangements, in-home services, health maintenance programs which can help extend independence and delay costly institutionalization.

The limits on private and public resources to provide needed services have never been more clear. It also has become just as clear that the answers of how to provide the needed facilities and services within the available resources will be found through: (1) research to determine trends and needs among the elderly and developing models for responding to those needs; (2) demonstration projects testing new concepts and models; (3) dissemination of new knowledge; and (4) through creation of a well-trained cadre of service deliverers.

The federal stake in such activities begins with its responsibility for the welfare of its citizens and ends with the need to use limited resources as efficiently as possible. For example, the administration and Congress are concerned about escalating costs of medical care. The Rural Health Center at the University of Florida believes that the cost of a health care outreach program for the rural elderly would quickly pay for itself if it only delayed or shortened institutionalization of clients by two or three months. How to locate and deliver care to the rural elderly in need is a challenge which can be solved only through research and demonstration projects.

Given those facts, the reasons behind the declining support for Title IV lies not with a diminished need for research, demonstrations, and education and training, but elsewhere. Unfortunately, in the yearly effort to maintain a useful level of funding, little attention has been paid to identify the "elsewhere". It seems most appropriate to do so now, in the process of considering reauthorization of the Older Americans

Act.

A reading of Title IV suggests several reasons why Title IV seems less important than it should:

- It is the only title in the Act without a purpose statement;
- It is poorly organized, with little logical flow to the collection of sections and parts which have been added over the years;
- It is less than clear on the level of effort which should be made to disseminate the results of research programs and demonstration projects and to whom.

That means there are no legislative purposes or goals which can be used in designing and evaluating an overall program, it is difficult to relate the various activities authorized by the title to each other, and dissemination efforts are left to the individual efforts of the grantee. As a result, audiences which ought to benefit from the results of Title IV activities, including the Congress, do not, or, at least, not to the extent they should.

Let me offer an example of how a Title IV program might be conceptualized from the viewpoint of serving selected audiences.

The three principal audiences could be: (1) Congress and the executive branch; (2) state and substate aging program planners and administrators; and (3) service deliverers, including educators, and trainers. While maintaining room to fund innovative, investigator-initiated research, a program could be designed to meet such information priorities as:

- For federal and state policy makers, information on demographic, economic, health, and other trends among the elderly, the kinds and levels of service needs the trends will create, and the kinds and numbers of personnel required to meet the needs;
- For state planners and service deliverers, information on designing and implementing comprehensive case management systems; and
- For service deliverers, information on home care and family assistance programs.

Obviously, for the sake of brevity, the list of research priorities is partial and illustrative rather than definitive, but even such a short list demonstrates how such an approach would give some coherence to a research/demonstration and dissemination program. (Congress, for one audience, would be well-served by such a program when it came to considering funding levels for other titles of the Older Americans Act and for Title IV education and training programs.) Also, the legislation ought not spell out goals as narrow as presented in my example. And finally, as part of a research/demonstration and dissemination program, Congress should continue support for on-going policy analysis programs, in which expertise and a data base can be built and developed over time, and for on-going centers which can synthesize and translate the lessons of research and demonstration projects into technical assistance for agencies in their regions or service areas.

Thus far, my comments have been personal observations which

I hope will be helpful in understanding the reasoning behind the formal statement of the Council of the Gerontological Society of America, approved March 3, 1984.

The Council recommended:

- o Statements of purpose and objectives for research/demonstrations, education and training, and special programs parts of the title;
- o Separate authorization levels for each of the four parts;
- o Stronger prohibitions against commingling of Title IV funds with funds from other programs, agencies, and departments;
- o Title IV authorizations of $40 million for FY 1985, $45 million for FY 1986, and $50 million for FY 1987;
- o A required annual report from the Admininstration on Aging to Congress on the activities of AoA in each of the parts of the Title IV, the progress made in meeting objectives set forth in purpose statements, the gaps that remain, and the strategies to be pursued to attain unmet objectives.

The Council suggested the following items be included in statements of purpose:

"Research and Demonstrations. The purpose of this part is to improve the quality and efficiency of programs serving the elderly population through research and/or demonstration projects which: (1) develop and synthesize knowledge about aging from multidisciplinary perspectives; (2) establish an information base of data and practical experience; and (3) plan, develop, implement, and evaluate innovative planning and practice strategies. Special emphasis should be placed on examining ethnic and cultural differences.

Research and demonstration projects should include plans and funds for dissemination of results, including concise policy or practice implications when appropriate. Such dissemination strategies should include Congress and the general public.

Investigator-initiated, as well as responses to requests for proposals, should be funded.

At a minimum, the research program should have, within three years: (1) established, in cooperation with other agencies, an on-going demographic data base providing information on the elderly population by age grouping, sex, race, geography, and such other categories deemed important to public policy needs; (2) identified and projected needs of older Americans; (3) determined the kinds and levels of programs needed to meet these needs; and (4) determined the kinds and numbers of personnel that will be required to meet those needs.

Education and Training. The purpose of this part is to improve the quality and efficiency of programs serving the older population through both short- and long-term education and training programs which: (1) train new professionals entering the field of aging, and (2) provide continuing education/in-service training for those already in the field. Special emphasis should be placed on addressing the lack of personnel trained to meet the community service needs of racial and ethnic minority elderly.

Activities under this part should also include dissemination of curriculum information and should facilitate the exchange of information and stimulate new approaches to activities related to the purposes of the Act.

In addition to conducting training and education programs, priority should be given to establishing education and training goals developed in conjunction with research on personnel needs.

Special Programs. An on-going base of assistance should be provided for policy analysis on aging issues and technical assistance to service delivery agencies."

Mr. Chairman, let me conclude this portion of my testimony by returning to my opening point - the importance of Title IV to the development of equitable, efficient policies in the field of aging. Decision makers need information on trends among and service needs of the elderly and about program options suggested by research and practice if they are to devise such policies. The field needs a growing pool of well-trained admininstrators and service deliverers for policies and programs to be implemented effectively.

Title IV of the Older Americans Act is the principal (in many cases, the only) source of funds which the federal government can use to generate the information it needs to act prudently and to encourage a continuing commitment to the education and training of personnel needed to serve the elderly population.

As mentioned previously, The Gerontological Society of America's Council also adopted the following recommendations to strengthen and improve the other titles in the Act:

General

- Extend the Act for at least a 3-year period through FY 1987
- Strengthen the leadership role of the Administration on Aging and of the Commissioner on Aging by requiring the Commissioner to report directly to the Secretary of DHHS rather than to the "office of" the Secretary
- Increase authorization levels to allow for program growth proportionate to America's expanding older population

Title III

- Maintain the basic structure of Title III with separate authorities and authorizations for III-B, III-C, and III-C2 with transfer capabilities
- Require that states, area agencies, and service providers give priority to meeting the needs of minority, low-income, limited English speaking, seriously impaired and isolated older persons
- Increase statutory recognition of the role of state and area agencies in developing community-based long-term care systems without diminishing other responsibilities
- Continue the priority on access, legal, and in-home services
- Provide statutory authority for those regulations recently

proposed for elimination which maintain the advocacy focus of the aging network, the emphasis on public, elderly citizen participation in all aspectrs of the program and affirmative action

- Relieve recipients of Title III funds from burdensome paperwork requirements but without compromising accountability
- Provide statutory mandate to States for advocacy assistance and education and training functions in Title III

Title V

- Maintain the current programmatic focus of the program
- Ensure the continued role of both state governments and national contractors in the administration of the program
- Encourage closer coordination between state government and national contractors in the administration of the program

Title VI

- Continue and expand the Title VI program of direct funding for Indian tribes

Senator **Grassley**. The meeting is adjourned.

[Whereupon, at 12:03 p.m., the subcommittee was adjourned.]

REAUTHORIZATION OF THE OLDER AMERICANS ACT, 1984

Title V—Community Service Employment for Older Americans

TUESDAY, MARCH 13, 1984

U.S. Senate,
Subcommittee on Aging,
Committee on Labor and Human Resources,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room SD-430, Dirksen Senate Office Building, Senator Charles E. Grassley (chairman of the subcommittee) presiding.

Present: Senators Grassley and Pell.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator Grassley. I am Senator Chuck Grassley, chairman of the Subcommittee on Aging. The Aging Subcommittee is a part of the larger full Committee on Labor and Human Resources.

Today, we meet for a hearing on title V. It is the last of several hearings we have had on the Older Americans Act and it is just prior to when we hope to have a reauthorization bill of the Older Americans Act before the end of this month.

We are dealing today with title V and this title is administered by the Secretary of Labor. Its purpose is to foster and to promote useful part-time opportunities for unemployed, low-income persons who are 55 years of age or older, and that is quoting from the act.

Under the Department of Labor, this purpose has been implemented in a program generally known as the Senior Community Service Employment Program. So that this committee might properly evaluate the past, present and future direction of title V, I requested the General Accounting Office in June of last year to review the executive branch proposal to transfer the administration of this community service-oriented program to the Administration on Aging within the Department of Health and Human Services.

Today, the General Accounting Office has delivered its review study. It makes no claim to be a comprehensive or verified assessment of every aspect of the program or how well it is currently operating and whether it should be moved.

This study does, however, reveal something of what the program is accomplishing in four important areas: one, participant eligibility; second, the administrative cost; three, transferring enrollees from subsidized to unsubsidized private sector employment; and, fourth, full use of those enrollees' positions established by the act and the Department of Labor regulations.

The most important findings of this General Accounting Office study appear to be these five facts. One, the Department of Labor has never conducted a formal evaluation of this program as it presently operates.

Second, the Department of Labor maintains little involvement in the direct operation of the program; in fact, none outside of the Washington, DC, area.

Third, neither legislation nor implementing regulations indicated clearly how the program is to be carried out.

Fourth, neither the Department of Labor nor the Administration on Aging has produced a rationale supporting the transfer of title V administration from Labor to the AoA.

Fifth, the General Accounting Office finds, based on "unverified report data and on a limited number of visits to local projects within three states" that the program has produced some positive results and that certain key program goals are being successfully met, and that no serious problem exists within the current program's operations.

The important words to note here are the GAO's admonition that theirs is an unverified, unaudited report from individuals involved.

The Committee looks forward to hearing from this morning's witnesses so that the Senate may learn more about how the 61,585 senior enrollees and the country are served by this $319 million program—a program that serves about 0.003 percent of the nation's elderly and uses about one-third of all Older Americans Act funds.

Other Senators are not here yet, so I will go on to the introduction of witnesses. But before I do that, I would like to ask everybody who is on the program for today to be cognizant of time constraints, and the reason for my doing that is because I have conflicts between this hearing, which we actually set up well over 2 months ago, and Finance.

I am going to have to stay here regardless of what is going on in Finance, but we are writing up a massive tax bill, and we have been over the past 2 weeks, and hopefully intend to get it done this week. That hearing will be carrying on through the rest of the morning and the early afternoon.

I would like to ask people who have not participated in these hearings in any way on Capitol Hill and maybe who are not familiar with the process—we do include in the record your entire printed statement and, of course, we will do that unless you object. So we would ask you to summarize wherever possible.

For those of you who appear regularly, I am sure you are used to that sort of procedure; for those of you who do not, you could take advantage of the time while I am hearing from the General Accounting Office as well as the first panel—you could go through your testimony and see how it could be summarized while the others are testifying as one way of shortening the process.

I would also, for administrative purposes, like to suggest that other Senators having conflicts like mine may not be able to come, although this set of hearings—I am surprised, compared to most hearings that subcommittees have that I have been associated with that do not have good attendance—both Republicans and Democrats on this Subcommittee have been very faithful in their attendance of these hearings on the Older Americans Act, and I want to say a thank you to my colleagues who have participated.

But for those who cannot come today, I would suggest that we are going to keep the hearing record open for 15 days so that anybody who is testifying can correct their testimony or add to it, if they desire. Anybody who was not invited to testify—if you want to leave a written statement for the record, assuming it is not too voluminous, it will be included for our consideration as well.

And then for any witness, you can expect Senators or their staffs who are not here to maybe submit to you questions in writing and we would like to have those responded to within that 15-day period of time.

Even on my own part, because of the time factor, I will be submitting some of my questions to the witnesses in writing.

The first witness is Mr. Morton Henig of the General Accounting Office. I want to thank you and members of your team who worked on this report, especially given the time constraints put on the GAO by the reauthorization schedule—constraints that precluded verification and audit methods that a longer study period would have allowed.

The report is nonetheless of genuine benefit to the committee, as it provides a picture of title V as a program that means many things to many people. To some, it is a welfare program; to others, it means community service, while others consider employment and training its prime purpose.

Last my constituent mail often praises title V as a well-intentioned and well-managed income maintenance program. Whatever it is, your testimony should prove interesting and helpful.

I would ask you to proceed, and I would also encourage you for the record, at least, to introduce your colleagues who are with you.

Before you do that, though, we have a statement from Senator Thurmond which we will include in the record at this point.

[The prepared statement of Senator Thurmond follows:]

STATEMENT BY SENATOR STROM THURMOND (R-S.C.) BEFORE THE SUBCOMMITTEE ON AGING REFERENCE TITLE V OF THE OLDER AMERICANS ACT, 430 DIRKSEN SENATE OFFICE BUILDING, TUESDAY, MARCH 13, 1984, 9:30 A.M.

MR. CHAIRMAN:

It is a pleasure to be here today to receive testimony on Title V of the Older Americans Act which provides a program of community service employment for older Americans.

Mr. Chairman, on June 28, 1983, the Administration recommended legislative changes to the Senior Community Service Employment Program (SCSEP), including the transfer of the program's administrative responsibility from the Department of Labor to the Administration on Aging (AOA) within the Department of Health and Human Services (HHS). In his budget proposal for fiscal year 1985, the President modified his June proposal to include only the transfer of the state grant portion of this program.

Only yesterday, the General Accounting Office (GAO) released a report which was very appropriately requested by you, Mr. Chairman, and which discusses this important program and the Administration's proposed changes. It appears from the findings of this report that more information is needed in order to determine the advisability of transferring all or part of the SCSEP program from Labor to HHS.

While the Administration's proposals to transfer SCSEP appear to be based on program philosophies -- that is, whether the program's purpose is employment and training or income maintenance -- I believe that a decision to transfer should also include other important considerations. Those considerations include program efficiency under the Labor Department and the ability of HHS to administer such a program.

Mr. Chairman, I am hopeful that we will learn more about these matters today. I want to welcome the many distinguished witnesses who are here today and I look forward to their testimony.

STATEMENT OF MORTON E. HENIG, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROGER I. PEET; THOMAS N. MEDVETZ; AND GASTON L. GIANNI

Mr. Henig. Thank you, Mr. Chairman. I would like to introduce my colleagues. First is Roger Peet, on my far left, and Tom Medvetz, who is next to me. They were the most directly involved in the review. Gaston Gianni, on my right, is the group director for GAO at the Department of Labor. As you indicated, I am an associate director with the Human Resources Division at GAO.

You have very succinctly capsulized the major portions of our report, so I am going to try and limit my testimony. There is prepared testimony which you can include in the record and I will go to page 2 which deals with the proposed transfer, and start there.

In June 1983, the administration submitted to the House draft legislation which would have significantly changed the program. It would have transferred the program from Labor by establishing a program of State grants for employment opportunities administered by the Administration on Aging in the Department of Health and Human Services.

The administration's rationale for the transfer was that the program's primary emphasis was on income maintenance and community service rather than on employment and training and, further, that the program was considered similar to other income maintenance and community service programs administered by HHS, and therefore its transfer would enhance the Government's ability to coordinate and administer it and other programs.

The administration subsequently modified this proposal in the President's fiscal year 1985 budget submission by proposing that the State grants portion of the program be administered by the Department of Health and Human Services and the national sponsors' portion by Labor.

I would like to discuss briefly what the program has accomplished, based on our evaluation of reported data. We will first deal with participant eligibility. The Older Americans Act states that the program is to serve persons 55 years and older, with priority given to those 60 years and older.

While some sponsors stated that emphasis was given to those over 60, this was not unanimous. Nevertheless, our review of the summary data shows that priority was being given to those over age 60. During the period 1981 to 1983, 77 percent of the enrollees were over 60 years of age.

Next, I would like to talk about administrative and matching costs. Labor regulations limit the amount of funds that can be spent on administrative costs to 15 percent of total program funds.

While the percent of Federal funds used for program administration by the national and State sponsors varies, they are for the most part meeting the 15-percent limitation. For example, during the program year 1980-81, State sponsors collectively and each of the national sponsors were below the 15-percent cost limit.

During program year 1981-82, three national sponsors exceeded this limit but by less than 1 percent, and during the following year two other national sponsors exceeded this limit but by less than two percent. In each of these cases, if you take the 2 years together, they were below the 15-percent limit.

Labor also requires sponsors to provide a 10-percent matching share of the grant amount. According to national and State sponsors, the 10-percent match is met through the provision of services, in-kind contributions, or cash.

Next, let me deal with the transitioning of participants into unsubsidized jobs. There is no legislative requirement that program participants be placed in unsubsidized jobs, but Labor has set a goal for transitioning. It was 10 percent in the 1977–80 period, then it went up to 15 percent after 1980.

The degree to which the placement goal has been met differs among the individual program sponsors for a number of reasons, including their emphasis on transitioning, the availability of jobs and transportation in rural areas, participant education and skill levels, and in some cases language barriers.

The overall percentage of enrollees transitioned during the period 1977 to 1983 exceeded Labor's placement goal, except for one year; that was 1980–81, and that was the year that Labor raised the goal from 10 to 15 percent. In the last program year, national sponsors transferred an average of 20.5 percent of their enrollees into unsubsidized jobs, with the range going from 34 percent down to 8 percent. For the States, it was 14.3 percent.

Several States were above that, with the range going from 60.5 percent in one State to zero in another.

The last measurable area that we looked at was the full use of enrollee positions. Funds are provided to program sponsors in support of a specific number of participant positions.

We noted that, overall, the program sponsors have maintained the number of positions at or above those specified levels, so the program has been operating at maximum capacity. For example, funds provided in program year 1982–83 were to maintain just over 54,000 positions, and the number of participants enrolled at the end of that program year was about 61,000.

One reason sponsors are able to support additional participant positions is that not all program costs, especially certain administrative costs, are charged against program funds. Thus, there are some additional funds available to support enrollee positions.

Next, let me deal with the basis for transferring the program. The proposal was based on the premise that the program was more of an income maintenance program than an employment and training program; that its transfer to an agency administering other income maintenance programs would allow more effective coordination and service delivery.

However, officials from Labor and the Department of Health and Human Services told us that there was no study or analysis made that demonstrated that the program would operate more effectively if moved, or that coordination would be improved. In fact, Labor has never conducted a formal evaluation of the program as it presently operates.

While those directly involved in Senior Community Service Employment Program operations have definitive views and opinions on whether the program should be moved, it appeared to us that those views were based on whether they believed the primary purpose of the program was employment and training or income maintenance.

Our review of the legislative history of the program indicated that the program has at least two goals. One is to promote employment and a second is to provide social services both to the community and to the individuals who are participants.

We did take a look at Labor's management of the program, although it was not a comprehensive look. As you know, Labor has had the program since 1967 when the operation mainstream demonstration project was transferred from the Office of Economic Opportunity to Labor.

Labor maintains more of a coordination, oversight and monitoring role, with relatively little involvement in direct program operation. The national sponsors and the State agencies have assumed day-to-day administration and management responsibility.

Labor carries out its role through 6 Federal representatives with monitoring responsibility for assigned national and State sponsors, usually 8 to 10 each. Labor does not have any field staff outside of Washington, DC, assigned to the program.

The monitoring responsibilities normally involve assessing compliance with grant agreements through reviews of performance and financial reports and occasional field trips to operational sites.

Because the proposed transfer did not include specifics on what changes would occur, certain questions remained unanswered. For example, the Administration on Aging's social service network is not employment-oriented and it is uncertain as to whether the agency would place the same degree of emphasis on transitioning older workers into unsubsidized positions.

This, plus a change in the fund allocation formula from that contained in title V of the Older Americans Act to the formula contained in title III, left unknown the effect on elderly worker participation in the program.

Furthermore, AOA has not developed an implementation plan, nor had it determined the cost of administration. Finally, the effect on coordination of having two agencies administer the program is uncertain at this time.

That completes my statement, Mr. Chairman. We would be happy to answer any questions.

[The prepared statement of Mr. Henig and responses to questions submitted by Senator Grassley follow:]

UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

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STATEMENT OF

MORTON E. HENIG, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON AGING

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON THE

PROPOSED TRANSFER OF THE SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Subcommittee, we are here today to discuss the results of our survey on the proposed transfer of the Senior Community Service Employment Program, authorized under title V of the Older Americans Act of 1965, from the Department of Labor to the Administration on Aging within the Department of Health and Human Services. We performed this work at your request as Chairman of the Subcommittee.

At the outset, I would like to point out that we limited the scope and duration of our survey in order to meet the needs of the Subcommittee within its established timeframe. In assessing the program's operations, we relied to a great extent on unverified, reported data and on a limited number of visits to local projects within three states. However, based on these efforts, it appears that the program has produced some positive results in that certain key program goals have been met. Furthermore, we found nothing in the way of studies, evaluations, or other documentary evidence to indicate that any serious problems existed with the current program operations or that the program would operate more effectively or that coordination would increase, if moved.

PROGRAM BACKGROUND

The Senior Community Service Employment Program was established to provide part-time employment for unemployed, low-income persons age 55 or older. Participants work in a variety of community service positions; for example, in day care centers, schools and hospitals. The program has been administered by the Department of Labor since 1967, and is carried out through grants to eight national non-profit sponsoring organizations and to units of State governments. These national and state organizations were provided a total of over $319 million for program operations during the period July 1, 1983 to June 30, 1984.

PROPOSED TRANSFER

In June 1983, the administration submitted to the Speaker of the House of Representatives draft legislation which would have significantly changed this program. The proposal would have transferred the program from Labor by establishing a program of state grants for employment opportunities administered by the Administration on Aging within the Department of Health and Human Services.

The administration's rationale for the transfer was that the program's primary emphasis was on income maintenance and community services rather than on employment and training. Furthermore, the Senior Community Service Employment Program was considered similar to other income maintenance and community service programs administered by HHS and, therefore, its transfer would enhance the government's ability to coordinate and administer it and other programs.

The administration subsequently modified this proposal in the President's fiscal year 1985 budget submission by proposing that the state grants portion of the program be administered by HHS. The national sponsors portion of the program would continue to be administered by Labor.

PROGRAM ACCOMPLISHMENTS

To gain an understanding of what the Senior Community Service Employment Program was accomplishing, we concentrated our efforts on four quantifiable goals established by the Older Americans Act or as stated in Labor regulations. These goals related to participant eligibility, administrative and matching costs, transitioning enrollees into unsubsidized jobs, and the full use of enrollee positions. I would like to briefly discuss each of these goals and the results, based on reported data, being accomplished.

Participant eligibility

The Older Americans Act states that the program is to serve persons 55 years and older, with priority given to those 60 years and older. While some sponsors stated that emphasis was given to those over 60, this was not unanimous. Nevertheless, our review of the summary report, dated June 30, 1983, for all sponsors for the 1981-83 program year period indicated that priority was being given to those over 60. During that period, 77 percent of the enrollees were over 60 years of age.

Administrative and matching costs

Labor regulations limit the amount of funds that can be spent on administrative costs to 15 percent of total Senior Community Service Employment Program funds. While the percent of Federal funds used for program administration by the national and state sponsors varies, they are, for the most part, meeting the 15 percent limitation. For example, during the program year 1980-81, the state sponsors collectively, and each of the national sponsors were below the administrative cost limit. During program year 1981-82 three national sponsors exceeded this limit but by less than one percent and during 1982-83 two other national sponsors exceeded this limit but by less than two percent. In each of these cases, the administrative costs calculated for the two year period (1981-83) are below the 15 percent limit. Labor also requires sponsors to provide a 10 percent matching share of the grant amount. According to national and state sponsors, the 10 percent match is met through the provision of services, in-kind contributions, or cash.

Transitioning participants into private sector jobs

While there are no legislative requirements that program participants be placed in unsubsidized jobs, Labor has set a goal for transitioning participants into such jobs. During the 1977-80 time period, this goal was set at 10 percent of total participants; beginning in 1980, the goal was raised to its present level of 15 percent.

The degree to which the placement goal has been met differs among the individual program sponsors for various reasons including the emphasis on transitioning, availability of jobs and transportation in rural areas, participant education and skill levels, and language barriers among enrollees. However, the overall percentage of enrollees transitioned during the period 1977-83 exceeded Labor's placement goal, except for program year 1980-81. It was during that program year that the placement goal was raised from 10 percent to 15 percent. In program year 1983, national sponsors placed an average of 20.5 percent of their enrollees in unsubsidized jobs, with a range of 34.3 percent to 8.2 percent. The average transition rate for the states was 14.3 percent. State placement rates ranged from 60.5 percent to 0 for one state and several territories.

Full use of enrollee positions

Funds are provided to program sponsors in support of specified numbers of participant positions. Our review of Labor records showed that overall the program sponsors have maintained the number of participant positions at or above these specified levels; therefore, the program has been operating at maximum capacity. For example, the funds provided in program year 1982-83 were to maintain just over 54,000 positions. The number of participants enrolled as of June 30, 1983, was about 61,000, 13.7 percent above budgeted capacity. One reason sponsors are able to support additional participant positions is that not all program costs, especially administrative costs, are charged against program funds; thus additional funds are available to support enrollee positions in excess of budgeted levels.

BASIS FOR TRANSFERRING SCSEP

The administration's proposal to transfer SCSEP was based on the premise that it was more an income maintenance program rather than an employment and training program, and that its transfer to an agency administering other income maintenance programs (the Department of Health and Human Services) would allow more effective coordination and service delivery. However, officials from Labor and HHS told us that there was no study or analysis made that demonstrated that the program would operate more effectively, if moved, or that coordination would be improved. In fact, Labor has never conducted a formal evaluation of the program as it presently operates.

While those directly involved in Senior Community Service Employment Program operations have definitive views and opinions on whether the program should be moved, such views appeared to be based on whether they believe the primary purpose of the program is employment and training or income maintenance. Our review of the legislative history of the program indicated that the program has at least two goals--to promote employment and to provide social services.

LABOR'S MANAGEMENT OF SCSEP

The Department of Labor has had administrative responsibility for the program since 1967 when the "Operation Mainstream" demonstration project was transferred from the Office of Economic Opportunity to Labor.

Labor maintains a coordination, oversight and monitoring role with relatively little involvement in direct program operation. The national sponsors and state agencies have assumed day-to-day administration and management responsibilty. Labor carries out its role through six federal representatives with monitoring responsibility for assigned national and state sponsors, usually numbering 8 to 10 per representative. Labor does not have any field staff outside Washington, D.C. assigned to this program.

Monitoring responsibilities normally involve assessing compliance with grant agreements through reviews of performance and financial reports and through field trips to operational sites.

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Because the proposed transfer did not include any specifics on what changes would occur, certain questions remain unanswered. For example, AOA's social service network is not employment oriented and therefore it is uncertain to what extent the agency would place the same degree of emphasis on transitioning older workers into unsubsidized positions. This, plus a change in the fund allocation formula from that contained in title V of the Older Americans Act to the formula contained in title III, left unknown the affect on elderly worker participation in the program. Furthermore, AOA has not developed an implementation plan, nor had it determined the cost of administration. And finally, the effect on coordination of having two agencies administer the program is uncertain at this time.

Mr. Chairman and members of the Subcommittee, this concludes my statement on the proposed program transfer. I will be happy to respond to any questions that you might have.

QUESTIONS FOR MORTON HENIG FROM SENATOR CHARLES E. GRASSLEY

QUESTION 1

What does the Labor Department do in the way of applying its employment expertise so that the national sponsors and enrollees benefit?

According to the Director of Special Targeted Programs in Labor's Employment and Training Administration, the Department's employment expertise is incorporated in the technical assistance provided to the national sponsors. He pointed out that Labor has provided a variety of information and guidelines on both subsidized and unsubsidized employment. He also noted that Labor had held, in November 1983, a working conference for experimental program sponsors to provide technical assistance on managing projects in the private sector.

This official explained that a variety of methods exist for disseminating technical assistance, such as assigning federal representatives, through telephone contacts, issuing Older Worker Bulletins, making site visits, participating in national sponsor working conferences, and conducting Labor's national program conferences.

This official also stated that the primary emphasis and goal of Labor's technical assistance is (1) to improve program administration through better management of resources and (2) to focus attention on program regulation and procedures. He added that this is consistent with Labor's decision to limit day-to-day direct involvement in program operations.

QUESTION 2

How would you interpret Section 502(d)(2) of the Older Americans Act? Does it apply to this process of allocating slots?

During discussions with your office, we were told that this question relates specifically to whether the decisions made by Labor, the national sponsors, and state organizations on the location of new or additional programs and enrollee positions, resulting from increased funding, are subject to the notice and hearing requirements of section 502(d)(2). The notice and hearing requirements of this section only pertain to the "proposed reallocation of programs" not the initial "distribution of programs." Therefore, the appropriation of additional funds, which allows for the creation and distribution of new enrollee positions, does not in itself trigger the notice and hearing

QUESTIONS FOR MORTON HENIG FROM SENATOR CHARLES E. GRASSLEY

requirements of this section. However, if in connection with the distribution of the new positions provided by additional funding, the Secretary of Labor proposed to reallocate the existing program distribution, then the notice and hearing requirements of section 502(d)(2) would apply. These requirements also could apply after the initial distribution of new enrollee positions if the Secretary subsequently proposed a reallocation.

QUESTION 3

If it (Section 502(d)(2)) conceivably does not apply, do you think that the process of allocating new slots, which must involve some rearrangement of old slots also, should be as private as it apparently is? The Federal Council on Aging has advocated that the states distribute their Title III monies according to a disclosure procedure open to public view. Do you think such a procedure should be followed for Title V?

We have no objection to making the process more public. In fact, GAO favors this policy, especially when federal funds are being spent.

QUESTION 4

On the basis of your study, would you say that the Labor Department should look further into the question of whether slots are equitably distributed?

On the basis of our limited work, we found no reason for Labor to look further into whether slots are equitably distributed. However, we would have no objection to Labor doing so.

As stated on page 22 of our March 12, 1984, report to you, the equitable distribution issue was addressed in our 1979 report to then Representative Charles E. Grassley and concluded that the national sponsors' criteria for distributing SCSEP (the Senior Community Service Employment Program) positions was designed, partly, to enhance administrative economy. In addition, although the sponsors' distribution of these positions had left many geographical areas unserved, their efforts to enhance administrative economy had merit when considered in relation to limited program resources and the significance of the program's administrative requirements.

QUESTIONS FOR MORTON HENIG FROM SENATOR CHARLES E. GRASSLEY

QUESTION 5

One of the proposals made with respect to Title V reauthorization has been that the allocation of Title V slots be made a part of the state plan on aging which is the responsibility of the governors. Do you think this would be a workable proposition?

Our review did not address whether such a proposal would be workable. However, based on work we are currently doing on the Job Training Partnership Act (JTPA) we have the following observations for the Sucbommittee's consideration.

The proposal is similar to requirements under JTPA, which provide for central coordination of program activities with the Governor's office. Also, under JTPA, opportunities exist for older worker participation. The governor, under section 124 of the act, is authorized to provide for job training programs which are developed in conjunction with service delivery areas within the state and which are consistent with the plan for the service delivery area prepared and submitted in accordance with the provisions in section 104 of the act, and designed to assure the training and placement of older individuals in employment opportunities with private business concerns. The funds available to carry out this training are provided for under section 202(b)(2) of the act which stipulates that three percent of the allocation of each state for each fiscal year shall be available to carry out section 124, relating to training programs for older individuals.

If the proposed change is made to Title V, the committee also may wish to provide for some formal tie-in to JTPA and the Governor's State Job Training Coordination Council.

QUESTION 6

Why has the Labor Department never conducted an evaluation of the program?

In response to our question, the Director, Special Targeted Programs reiterated the position stated before your subcommittee on March 13, 1984, in which they admitted that no formal evaluation had been made. However, he pointed out that Labor does monitor the program regularly. Labor's past evaluation priorities have been directed toward larger programs and in that context, Labor has not evaluated the program.

QUESTIONS FOR MORTON HENIG FROM SENATOR CHARLES E. GRASSLEY

Labor's Inspector General advised us that it is currently reviewing selected aspects of title V of the Older Americans Act, including the need for and feasibility of making a program effectiveness review.

Senator **Grassley**. Well, thank you very much. Again, I think I cannot overemphasize too much the cooperation that this subcommittee has had with you and your staff in helping us get—even though it may not be as all encompassing as we had hoped, at least to get a handle on the program through your review in the period of time since last June, I think it was, when we requested this. I want to thank you again.

You pointed out in your introductory statement that you limited the scope and the duration of your survey to meet the requirements of the subcommittee's schedule. I take it that you would not characterize your study of the title V program as a complete and thorough evaluation, and that you are not therefore able to make a definitive assessment of how well the program is currently operating.

Approximately how much time and effort were you able to commit to your study of the program?

Mr. **Henig**. We had a little over 4½ months and we had approximately four people working on it. We would normally go through a survey period, which is all we were able to accomplish at this point, that generally takes about 4 months. This involves getting the background information, going through the legislative history, trying to find out how the program operates at various locations.

When we go into a more detailed review, we actually test records to make sure that the information being reported is accurate. For example, if a sponsor reports so many people transitioning from subsidized to unsubsidized employment, we would have to go verify that that is accurate.

If we are going to talk about administrative costs, we would do some audit work of the actual costs. We were unable to do that.

So a more complete audit would have taken a lot more time and would have been carried out at many more locations for us to have made a more definitive judgment on the actual operation of the program.

Senator **Grassley**. OK. By any chance, are you familiar with the Morgan Management study of the program? If you are, how much time was available for that study, to your knowledge?

Mr. **Henig**. I am familiar with the study. I would let one of my colleagues answer as to how much time was available for that study.

Mr. **Medvetz**. I believe that study transpired over about a 6-month period of time.

Senator **Grassley**. A 6-month period of time?

Mr. **Medvetz**. Yes.

Senator **Grassley**. Would it be fair for me to say that it is also not a definitive analysis of the title V program from your point of view?

Mr. **Henig**. No; it was not. In fact, Morgan Management said that it was not a definitive study of the program. They did not go out and do any verification or analysis; they used mostly reported data.

Senator **Grassley**. To what extent did you analyze the Labor Department's management of this program?

Mr. **Henig**. I could not say we analyzed Labor's management. We found out what the people do. As we indicated, they really do not manage the program; they have a monitoring role. The program is essentially managed by the major contractors and the State agencies—the day-to-day management of the program.

Senator **Grassley**. So Labor's role is monitoring as opposed to managing?

Mr. **Henig**. Yes; that is how I would characterize it.

Senator **Grassley**. With respect to participant eligibility, you stated in your report to the subcommittee that although the law requires that priority be given to those over 60, not all the sponsors or States appeared to do this.

Should the Labor Department be doing more to ensure that all the national sponsors give priority to those over 60, or would you say there are compelling reasons which justify the departure from the law?

Mr. **Henig**. Again, not having audited any of the data that is reported, if we had found, say, 77 percent of participants were over 60 years old, we would probably not make a recommendation to the Department that they do more than they are probably already doing.

That seems to be a fairly reasonable compliance with the law, which establishes 55 as the minimum age, with priority given to those age 60 and over. I would say that the sponsors and the States seem to be doing a fairly good job.

Senator **Grassley**. You pointed out in your study that enrollees can be employed in administrative capacities by the national sponsors and the States, and be paid for this out of the enrollees' funds rather than out of the allowable 15 percent of the program funds.

This would seem to imply that the resources being devoted to program administration are greater than shown in your study. Do you agree with this, and do you have any idea how much greater the percentage of program funds devoted to the administration is when the enrollee contribution to administration is factored in?

Mr. **Henig**. Yes, I would agree with that statement. As you know, the law does permit—in fact, it probably encourages the sponsors to use enrollees in this manner. Again, we did not audit administrative costs, so if I say that they are at a certain level, that is what it is reported to be.

But even with factoring in the value of the enrollees who work in administration processes, it would still be under 15 percent, as of the latest contract year.

Senator **Grassley**. Even factoring that in?

Mr. **Henig**. Yes. It was about 11.5 percent, something of that nature, and I think there were enough enrollees at least reported working with the sponsors that if you priced them out, it would still be under 15 percent.

Senator **Grassley**. Were you able to determine how much technical assistance the Labor Department provides to the national sponsors or any of their subcontractors?

Mr. **Henig**. We talked to the Labor people about that. I would not be able to quantify a specific amount of technical assistance. Most of what they did was responding to questions by the operating units, the State agencies or the national contractors over the phone. That was the predominant technical assistance mode.

We did speak to the State agencies and the contractors at the local level about the amount of technical assistance they were getting and they felt it was about the right amount. They sort of liked the system the way it operated.

Senator **Grassley**. In your report you mentioned that the Labor Department made only 28 onsite visits to 26 grantees in 1983. What percentage of the total operating sites does this represent?

Mr. **Henig**. A very small percentage. Of the 28 visits, I think 19 were to State agencies, and that would be perhaps up to a 3-day visit and the Labor Department monitor would then go down to some of the local sites.

Also, seven of the national contractors were visited; a couple of them twice. Again, they would be visits to a local operating sponsor, but there are over 500 local sponsors, so the number visited was probably not more than a small percentage.

Mr. **Gianni**. Senator, I would like to add something on that.

Senator **Grassley**. Yes.

Mr. **Gianni**. Several years ago, GAO reported to Senator Hatch about how the Office of National Programs was operating and one of the areas that we found in need of improvement was the degree to which the Department conducts monitoring activities of its grants and contracts. (Labor Needs To Better Select, Monitor and Evaluate Its Employment and Training Awardees, HRD-81-111, August 28, 1981.)

After issuing that report, our recommendation was that this type of activity needed additional emphasis, the Department set a goal that they would conduct monitoring visits at least once a year. In this particular case, the Department has not been able to reach that goal. They attributed it primarily to limitations in travel funds.

Senator **Grassley**. You mean they were committing themselves to go to each site once a year?

Mr. **Gianni**. I believe it is to each contract or grant, which would be the 57—State organizations plus the national sponsors.

Senator **Grassley**. Were you able to make any assessment of the types of jobs into which enrollees are transitioned or the duration of these jobs? I guess what I want to know is how long enrollees remain employed after they leave enrollee status.

Mr. **Henig**. No, we were not able to do that. The central data is not sufficient to make that kind of analysis. You would have to go out to the local sites to get that kind of information. It would have been rather time consuming to get that.

Senator **Grassley**. In what ways does the Labor Department help the national contractors in their efforts to move enrollees into private sector jobs?

Mr. **Gianni**. Basically, a major portion of the act has provided for the Department to conduct demonstration projects, and over the past several years the Department has conducted a number of demonstration projects directed at transferring individuals into private employment.

The Department is currently in the process of preparing a report to the Congress on the results of these demonstration projects. I would think the major emphasis of the Department is encouraging people to transition and demonstrating how these individuals can be transitioned.

In addition, the Department has set up transition goals and, as a result of some of the direction from Congress, has recently increased that goal from 10 to 15 percent. So I believe those types of actions are encouraging the sponsors to pay attention to that particular area.

Senator **Grassley**. I want to ask about the employment slots and how they are divided up. In your report you described in 1983 that they were distributed among the sponsors and the States by a process in which the Department, the national sponsors and the States would meet in Washington, and then a few days later the national sponsors and the States usually give the Labor Department a chart of the proposed distribution of their positions.

You noted that in 1983, the Labor Department did not accept the sponsors' proposed allocation of slots and instead developed a different allocation. So my question in regard to this is whether or not the Labor Department in earlier years usually accepted the sponsors' proposed allocations.

Mr. **Henig**. Yes, they tended to accept it.

Senator **Grassley**. I gather from your report that no aspect of this allocation process was open to the public; is that correct?

Mr. **Henig**. The allocation of new slots, the additional slots over what was already out there—that was done at this meeting we described in the report; it was sort of like a closed meeting.

The rest of the process is, I would say, open in the sense that the allocation of money is by formula or by the appropriation process. It is only the new slots, I would say, that took place over a couple-day period and, no, there was no public notice; there was no preparation of minutes or anything like that that you could look at.

Mr. **Medvetz**. Relatively speaking, very little of the slot allocation takes place in a closed-door forum. For the most part, the slots are allocated on a historical basis—what took place in the past. The same level of activity is maintained. It is the new slots which I mentioned are relatively small in number that are allocated in a closed-door session.

Senator **Grassley**. I will have some other questions on that point, but I think I will ask you those in writing. I want to thank you very much for participating and, for a third time, thank you very much for your cooperation on helping get this report to us in a short period of time that we requested it.

Mr. **Henig**. It was our pleasure.

Senator **Grassley**. Thank you.

Our next group of witnesses will be the first of two panels comprised of title V sponsoring contractors. These are the organizations that are assigned 78 percent of the funds and job slots comprising the primary scope and service of this important part of the Older Americans Act.

From left to right, we have Ruth Kobell of the National Farmers Union; Don Reilly, deputy executive director of the National Council on Aging; Leon Anderson of the Forest Service of the USDA; and William Hutton, executive director of the National Council on Senior Citizens.

Would you proceed, then, Ruth?

Ms. **Kobell.** Yes.

Senator **Grassley.** And I want to acknowledge that Ruth, over the period of the 10 years I have been in Congress, has been an active participant in questioning and testimony before aging committees. I used to be a member of the House Aging Committee, and that is where I first met her. We have had a close working relationship with you and we appreciate your coming.

STATEMENT OF RUTH E. KOBELL, LEGISLATIVE ASSISTANT, NATIONAL FARMERS UNION; DONALD F. REILLY, DEPUTY EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON THE AGING, INC.; LEON H. ANDERSON, DIRECTOR, HUMAN RESOURCE PROGRAMS, FOREST SERVICE, U.S. DEPARTMENT OF AGRICULTURE; AND WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Ms. **Kobell.** Thank you, Senator. I always appreciate the opportunity to work with you on these very important issues.

The National Farmers Union has, of course, supported the Older Americans Act. I appreciate your reiterating that our statement in full will be placed in the record.

We want to be brief this morning so that you have an opportunity to raise the questions that are needed.

We have supported the Older Americans Act since it was first developed in the 1960's, and enacted in 1965. At that time, we also promoted the concept of an older worker program after our studies of rural poverty in the 1960's, and have been proud to continue to sponsor Green Thumb over the intervening years.

We appreciate the bipartisan support of Congress over those years in building this program from a very small beginning. We recognize that we still reach less than 1 percent of those who are eligible. This program, of course, is specifically targeted to economically disadvantaged men and women.

I think one of the challenges always is that those people most in need are first identified and then the community service employment opportunity is sought to use their specific skills and experience.

We believe that the Senior Community Service Employment Program has been successfully fulfilling its legislative mandate which covers four general areas: first, to provide employment for eligible individuals in their communities with public or private, nonprofit agencies or organizations; to provide services which contribute to the general welfare of the community; to provide training to make the most effective use of the skills and talents of the workers; and to assist those workers who wish to find unsubsidized employment.

As you know, there has been increased attention to helping people move off the program and into private employment opportunities. We recognize that this is one of the important ways to stretch the resources and make this program make available to more people.

However, we would be anxious to point out that by the very concept of this historic employment and work opportunity program to assist those people who are economically disadvantaged, we do not expect that it would be possible to transition to private employment at any time for more than a limited number of title V workers.

Green Thumb now operates programs in 45 States and in Puerto Rico, and we have historically, because of the rural orientation of their sponsor organization National Farmers Union, maintained program activity in rural areas. We believe that there is a special need to reach out to people in rural communities who often are bypassed by other programs to help in delivering this service.

In 1981, you will remember that the legislation targeted up to 3 percent of the funds for title V to carry on special training and placement efforts, and Green Thumb has been actively involved in this. They asked their State directors to come up with special programs which tried to use new and different techniques to develop training for title V eligible older people.

Of course, Green Thumb staffs continually provide training as part of the support program to the workers. Out of this special new effort, they have in 1 year helped about 200 people go through special training, which included home health care, some computer technology, word processing; worked with a group of credit unions to develop special credit union accounting procedures, and then helped them in placing these older workers into permanent jobs.

There were many challenges with this. Employers and instructors often showed age bias because they had not been accustomed to training this age group of people, many of whom had been out of the work force for a long time.

In one case, older people and younger people worked in the same computer class and they said this turned out to be a very productive experience because both the older people and the younger people got some interaction themselves that was useful.

As was pointed out, I believe, the Department of Labor is developing a report on this, as are our people, and we would be glad to share the Green Thumb report with you.

I wanted to care your attention to a recent article in the Washington Post on the research done by the University of Michigan on poverty which points up the value of giving people a step up in trying to change their poverty status.

The National Farmers Union policy statement called for a 5-year extension of the act, and some adequate increase in authorization levels to accommodate the continuing support which Congress has demonstrated for this program.

I thank you for the opportunity to present this statement.

[The prepared statement of Mr. Kobell and responses to questions submitted by Senator Grassley follow:]

NATIONAL
FARMERS
UNION

TESTIMONY

OF

RUTH E. KOBELL
LEGISLATIVE ASSISTANT
NATIONAL FARMERS UNION

REGARDING

REAUTHORIZATION OF THE OLDER AMERICANS ACT

TO

SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

MARCH 13, 1984

Mr. Chairman:

I am Ruth E. Kobell, Legislative Assistant, National Farmers Union, Washington, D.C. We appreciate the opportunity to testify in support of reauthorization of the Older Americans Act Amendments of 1965 and to speak specifically to Title V, the Senior Community Service Employment Program.

National Farmers Union has supported the Older Americans Act since the legislation was first developed in the 1960s. We believe that the programs of advocacy and development of services, the nutrition programs, the research, education, and training and the sponsorship of special projects, such as the White House Conference on Aging have been extremely valuable. We look forward to working with you in stengthening the Older Americans Act and the appropriations necessary to carry out these programs.

Delegates to the National Farmers Union Convention meeting in New Orleans this week have included the following statement of support for the Older Americans Act, the Senior Community Service Employment Program and the Green Thumb program in their policy for the coming year:

"Older Americans Act

"In keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our nation are entitled to full and free enjoyment of a secure and active involvement in our society. The Older Americans Act is one of the programs that has special impact on older men and women and has served our nation well since its enactment in 1965.

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"We support a five-year extension of the Older Americans Act Amendments, with adequate increases in authorization to provide Congress the authority to allocate needed resources for the various programs.

"We recommend that Title IV, which authorizes research, training, and demonstrations, be strengthened to clarify the scope and purpose of these programs. Authorization ceilings should be raised to recover recent sharp reduction in funding, and reporting provisions should be strengthened. Research should be targeted to problems and concerns of older people in rural communities.

"Title V, the Senior Community Service Employment Program, should continue to be administered by the Department of Labor through grants to national organizations and state governments. Authorization levels should be increased to reflect both the increases in enrollee costs and to provide Congress the opportunity to increase employment opportunities for the many unemployed low-income older Americans who are ready, willing, and able to provide services to their communities.

"The number of older Americans continues to increase in our society and efforts must be redoubled to make use of their experience, skills and energy to fill the needs of our society, through both employment, citizen involvement and volunteer activities.

"Senior Community Service Employment Program

"We are grateful for the increase in appropriations provided through the bipartisan support in Congress for the Senior Community Service Employment Program, Title V of the Older Americans Act, under which Green Thumb is authorized, which provides $317.5 million in FY 1984 to provide 62,500 jobs for economically disadvantaged older men and women to deliver needed services in ther communities.

"Green Thumb is authorized under grant with the Department of Labor to make available 17,317 work opportunties to older Americans in 45 states and Puerto Rico, and gives needed assistance to some 10,000 host agencies to deliver services to rural communities which would not otherwise be available. They also work with employers to develop employment opportunities for Green Thumb and other older workers.

"We urge Congress to continue the Senior Community Service Employment Program as a separate categorical program under administration of the Department of Labor and provide full funding at authorized levels."

The Older Americans Act has developed a well established network of services to communities in support of their senior citizens, in addition to other income, health and social services such as Social Security, Medicare and Medicaid. We believe the present law needs only minor changes, including adequate increases in authorization levels. We recommend that you consider a 5-year reauthorization of these programs in recognition of the continuing support needed by this rapidly increasing segment of our population.

The nutrition programs which provide both group and home delivered meals are particularly important in helping older people stay healthy, independent and active in our communities. We urge that you retain separate funding for nutrition services and supportive services so that the funding for meals which is even now inadequate to serve more than one-third of the people who need them, won't be decreased in competition with other needs. Nutrition services should be targeted to older individuals at nutrition risk with special attention to isolated individuals in rural areas.

We are glad that over 2,000 Green Thumb workers, (11 percent of our enrollees) work in local nutrition programs and 400 more help provide transportation to bring rural people into the meal sites and take care of other needs.

We believe that the research, education and training programs under Title IV of the Older Americans Act will become increasingly important if we are to meet the needs of older people and make the most effective use of available resources in the years ahead. Title IV has suffered almost 60 percent reduction in funding during the last three years. We recommend authorization ceilings be raised to reflect future needs and that reporting requirements are strengthened to make the results of these programs more useful to Congress and the public.

We want to particularly discuss with you the Senior Community Service Employment Program, Title V, under which Green Thumb Inc. is authorized and funded. The concept of using older economically disadvantaged rural men and women to deliver needed community services and supplement their limited income grew out of studies sponsored by National Farmers Union in the early 1960s. The report of the National Policy Committee on Pockets of Poverty called for a federal agency to deal with poverty and report directly to the President of the United States. The 1960 Census had shown one and a half million farm families, 14 million persons, living in poverty in rural America. Many older people felt the adverse economic impact of the mechanization of agriculture. Many of the younger members of farm and rural communities moved to the big cities, but older people found it difficult to leave their home and yet there was little chance to get jobs. There was little social security coverage for farmers who had been brought into the program less than a decade earlier.

The concept embodied in SCSEP of using the skills, commitment and experience of older men and women to provide those services that are not otherwise available in their communities, has found broad bipartisan support in Congress over the last 18 years. SCSEP has pioneered the right and need of older workers for paid employment at useful, needed jobs and has targeted available resources to those in greatest need.

While SCSEP now provides 62,500 jobs for senior workers across the nation, it is estimated that this still meets less than 1% of the employment opportunities needed for those eligible under the program.

We believe the Senior Community Service Employment Program is successfully fulfilling its legislative mandate to 1) provide employment to eligible individuals in their communities with public or private nonprofit agencies or organizations; 2) to provide services which contribute to the general welfare of the community; 3) to provide training to make the most effective use of the skills and talents of the workers; and 4) to assist those workers who wish to find unsubsidized employment.

Green Thumb operates in primarily the rural areas of 45 states and the Commonwealth of Puerto Rico. In the current grant period, July 1, 1983 to June 30, 1984, we have funds to provide 17,317 employment opportunities, including Title V funds from the Governors of 7 states. These enrollees are placed in approximately 9,000 host agencies in over 1800 counties. This work includes both crew projects such as weatherization of low income homes and building and maintaining parks and other conservation projects, and single placements with host agencies such as senior centers, schools and libraries. Sixty percent of our enrollees are women.

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As of December 31, 1983, 12,572 workers were placed in agencies providing services to the community at large and 6,345 worked in providing services to the elderly of their communities. We believe the emphasis on work in the community based programs gives our workers greater opportunities to change common stereotypes about older workers. This is one of the Missions of Green Thumb. I quote from their policy and procedures manual:

> "1. To Change Stereotypes. Demonstrate to the Nation, primarily through the rural older worker program, that older Americans can and should work for reasons of their personal, monetary and psychological benefits and for community betterment, providing tangible capital results, decreased dependence on public assistance, and improved human group associations."

SCSEP is and has been developed as an employment program and we therefore believe it is appropriate to continue administration of Title V in the Department of Labor. By working as partners with employment services, educational and training programs, and demonstrating that Title V enrollees are good prospects for jobs, we accomplish the objective of keeping and returning older Americans to the work force when they need and desire a job.

We sometimes fail to emphasize the continuing effort of Green Thumb staff to help workers improve their work attitudes and skills through regular seminars and training sessions. They also are able to arrange for specific training to improve the skills of individual workers.

Missouri Green Thumb arranged for June to take a ten-hour beginning computer class in Chillicothe on her own time so that she was able to use a machine when it was installed at her place of work. Quentin received computer training while working as a teacher's aide at Vo-Tech in Kirksville. Older workers in rural communities often find it difficult to arrange such training on their own.

In the 1981 Older Americans Act Amendments, Congress targeted up to 3 percent of Title V grant funds for special training and placement efforts to place Title V eligible applicants in private employment.

Green Thumb invited their state directors to propose special innovative programs that would provide such opportunities and demonstrate the viability of training older workers in new, marketable skills. We are proud of their efforts.

They placed about 200 workers in a variety of training programs, including home health aides high tech assembly, word processing, credit union accounting and factory assembly. In most cases it was the first time that employers and instructors had worked with students of this age group. Age stereotying was evident. Some of the enrollees were unsure they could do the work. In one instance older and younger students worked together in the same class and it proved to be a very successful experience. Placement rates have been encouraging. We will be glad to share further details of the programs with your staff for review and would encourage on-site visits by members of Congress.

I was interested in the article in the March 8, Washington Post, reviewing the long-term study on poverty at the Institute of Social Research of the University of Michigan. It reported that more than fourth of all Americans lived in poverty at one

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time or another in the 1970s even though the official poverty rate was never over 12.8 percent in any one year. The study suggests that most of those who slip into poverty do so for short periods after major adverse events.

While only about 2 percent of those who experience poverty remain persistently poor, one-third of those are old or living with families headed by the old, forty percent live in households in which the head of the family is disabled, two-thirds live in the South and most live in rural areas, according to the study.

The success stories reported by Green Thumb and other SCSEP programs demonstrate again and again that when our workers, who are among that third who are old and living in poverty, are given a hand up, many of them can move out of the ranks of poverty and all of them can continue to contribute to their communities and increase their incomes and maintain their independence. Let me cite a few examples:

Older women are the fastest growing group moving into poverty. But a lady in her 70's is piloting a mini-bus around Cherokee, Iowa, providing much needed local transportation, because we have a Green Thumb program available in rural communities. Another assists in preparing 50 to 60 meals a day at the Boone County Child Care Center. Another is helping at the Head Start Program in Independence.

Bill is now an employee of the Akron-Westfield Community School District because he was able to prove his abilities as a part-time Green Thumb worker in the Library. His background as a retail clothing salesman and buyer for 28 years gave him the needed experience in dealing with people and his eagerness to learn new skills helped him start this new career and open up another job opportunity for an older worker. But it took the availability and support of the Green Thumb program to give him his chance.

Green Thumb has expanded their efforts to meet increased demand for food for the unemployed and other needy persons. In California, they are increasing their assistance to agencies which are involved in food production and distribution. With close to a year-round growing season, their community garden grown food stuffs are distributed to senior and day care centers through the year. Government surplus foods are also being distributed by Green Thumb workers through their community agency work assignments and they often are part of community networks that can reach out to those in need who are often not otherwise found.

Green Thumb continues to make every effort to improve the quality and the efficiency of their administration of the increased Federal funds provided by Congress. They maintain an internal auditing and monitoring staff to assure an on-going compliance with both law, DOL regulations and Green Thumb policy and procedure manuals. State office budgets monitored through computerized payroll and accounting methods strive to deliver an increasing share of their grant funds directly to worker wages.

Green Thumb works closely with State and Area Aging Agencies and other national contractors to refine the equitable distribution of Title V resources. They have not only developed their own network of recruitment of eligible workers in rural areas that often lack employment offices, but they have established recognition and a reputation for reliability among the rural employers. A state director recently wrote me: "The 192 people, age 55 and below poverty, in the rural part of the county, are just as needy as the 2496 people in town but it takes an organization that is rural oriented to find and help them."

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Of course, it often costs more to deliver services to rural communities and rural citizens. There are more miles to cover which costs both time and travel money. Even with careful scheduling, the quality of the program is related to adequate supervision. Jobs must serve the community, and must develop the potential of the worker. Green Thumb has a skilled and dedicated staff who strive to meet expanding community needs and improve program quality.

Other expenses are harder to control. Social Security taxes are increasing. So are workmen's compensation rates, even though Green Thumb carries on an active safety program in cooperation with their insurance company. Telephone rates increase, as do other costs.

We are glad that Congress has seen fit to increase funding for Title V up to authorized funding levels. Last spring, they had to secure a special waiver for the Title V funds provided in the Emergency Jobs bill which brought funding to $319.5 million, some $23 million over the FY 1983 authorization level.

We urge you to increase and target authorization levels to provide for increased costs and continuing growth in recognition of the needs of both community services and older workers. We believe that levels of $340 million for FY 1985, $370 million for FY 1986 and $400 million for FY 1987 would be targets reflecting past Congressional support.

We look forward to working with you in support of prompt passage of this important legislation.

Thank you.

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OMB Approval No. 44-R1480

U.S. DEPARTMENT OF LABOR • Employment & Training Administration

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM – QUARTERLY PROGRESS REPORT

PROJECT SPONSOR Green Thumb, Inc.	REPORT PERIOD ENDING (Month & Year) September 30, 1983	PROGRAM NO. 41
CITY AND STATE Arlington, Virginia		TYPE OF REPORT (Check One) ☒ Interim ☐ Final
AGREEMENT NUMBER 99-3-0093-11-169-02	SUBPROJECT NO. 0[illegible]	PROJECT PERIOD From July 1, 1983 To June 30, 198-
NO. ENROLLMENT POSITIONS ESTABLISHED ➤ ➤ 17317	UNSUBSIDIZED PLACEMENT GOAL ➤ ➤ 2595	

A. ENROLLMENT LEVELS (Number of Enrollees)

1. Carried over from previous period	18942	3. Placed in unsubsidized employment this project	3a 573	3b 1/ 28	5. Current enrollment (End of Period)	[illegible]
2. Started under the project	2258	4. Other terminations this project	1374		6. Enrollment vacancies (End of Period)	[illegible]

B. JOB INVENTORY

SERVICES TO GENERAL COMMUNITY	NO. JOBS	SERVICES TO ELDERLY COMMUNITY	NO. JOBS
1. Education	3522	11. Project Administration	[illegible]
2. Health and Hospitals	709	12. Health and Home Care	[illegible]
3. Housing/Home Rehabilitation	357	13. Housing/Home Rehabilitation	[illegible]
4. Employment Assistance	322	14. Employment Assistance	[illegible]
5. Recreation, Parks and Forests	1761	15. Recreation/Senior Centers	[illegible]
6. Environmental Quality	531	16. Nutrition Programs	2079
7. Public Works and Transportation	2070	17. Transportation	[illegible]
8. Social Services	1343	18. Outreach/Referral	[illegible]
9. Other	1966	19. Other	[illegible]
10. TOTAL (1 - 9)	12661	20. TOTAL (11 - 19)	[illegible]

C. ENROLLEE CHARACTERISTICS

	CHARACTERISTICS	STARTS (Cum.)	CUR. ENROLL.		CHARACTERISTICS	STARTS (Cum.)	CUR. ENROLL.
SEX	Male	[illegible]	7652	ETHNIC GROUPS	White (not Hispanic)	[illegible]	[illegible]
	Female	1315	11288		Black (not Hispanic)	257	[illegible]
EDUCATION	8th & Under	[illegible]	7795		Hispanic	60	[illegible]
	9th - 11th	513	[illegible]		American Indian or Alaskan Native	30	[illegible]
	High School Grad or Equivalent	695	5132		Asian or Pacific Islander	15	44
	1 - 3 years College	217	1423	AGE	55 - 59	788	3413
	4 yrs. College or more	65	433		60 - 64	702	[illegible]
Family income at/below Poverty Level		1772	[illegible]		65 - 69	432	[illegible]
Veteran		513	[illegible]		70 - 74	226	[illegible]
D. AVERAGE HOURLY WAGE/CURRENT ENROLLMENT			$3.39		75 and Over	107	2376
E. NARRATIVE REPORT (Attachment)				SIGNATURE		DATE	

Formerly MA 5-109 1/ Persons placed in supplemental jobs but not terminated from the program ETA 5140 (Rev. May 1978)

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Thursday, March 8, 1984 THE WASHINGTON POST

New Data Change Picture of Poverty

1 in 4 Americans Poor at Times in 1970s

By Philip J. Hilts
Washington Post Staff Writer

More than a fourth of all Americans lived in poverty at one time or another in the 1970s even though the official poverty rate was never over 12.8 percent in any one year, according to a new book that challenges popular beliefs about the poor in America.

The new survey, with other emerging data, has begun to alter the long-held image that the poor in America form a permanent underclass locked into a "culture of poverty" with little chance of escape.

The long-term study by the University of Michigan suggests that most of those who slip into poverty do so for short periods after major adverse events, such as divorce. Immediately after divorce, for instance, a divorced woman's income is cut in half on the average, and rises again only on remarriage.

Only a small percentage of those who experience poverty remain persistently poor—about 2 percent of the U.S. population compared with 25 percent who experience short spells of poverty.

Long-term poverty strikes blacks in much higher proportion than whites—62 percent of the persistently poor are black. But, contrary to the popular picture, they are mostly not able-bodied urban welfare mothers or young, unemployed men. Nor are they apathetic or averse to advancement.

The Michigan study shows that the small number of people who are persistently poor fit a completely different profile:

- One-third are old or live in families headed by the old.
- Forty percent live in households in which the head of the family is disabled.
- Two-thirds live in the South, and most in rural areas.

Age-old arguments about whether the poor have behavioral patterns that trap them in self-perpetuating poverty are challenged in a new book, "Years of Poverty, Years of Plenty," that tracks family incomes over decades instead of taking one-time "snapshots" of poverty.

"The discussion of the issues in the 1960s generated more heat than light, partly because of a lack of the necessary data to test the theories," wrote Greg J. Duncan and his colleagues Mary Corcoran and Patricia and Gerald Gurin, recently in a paper summarizing the material in the book.

"The discussions in the 1960s, when based on data at all, tended to draw upon . . . small and potentially unrepresentative areas and populations. Today more relevant and empirical data are available," they said.

The Duncan book is based on the largest and longest term study ever done on family income changes. It reports the findings of a study by the University of Michigan's Institute for Social Research which followed 5,000 representative American families for 15 years.

The new view of poverty also appears in a 40-year follow-up study of inner-city children published in the March issue of the American Journal of Psychiatry.

The massive Michigan study shows that one quarter of the U.S. population fell below the official poverty line for one or more years during the decade of the '70s. But less than one-tenth of them were persistently poor through eight or more of the 10 years.

George E. Vaillant of Dartmouth Medical School writes in the current American Journal of Psychiatry that "at first, the certainty of a self-perpetuating underclass appears so obvious as to require no proof."

"It seems that deprivations in childhood—which may induce malnutrition, abuse, overcrowding, unstable living situations, gross neglect, and inferior education and socialization—can only produce young adults with low levels of . . . work skills and with high levels of social distrust, hostility and alienation . . . . Thus, in the mid-1960s, Oscar Lewis introduced the idea of a 'culture of poverty,' in which maladaptation is passed on from generation to generation."

But in the data from Duncan and Vaillant, a majority of children from impoverished homes escape poverty. Vaillant used data going back to 1940 on 456 Boston children, half of whom were from mostly white impoverished homes plagued by abuse, alcoholism and numerous other problems.

When 425 of the 456 persons were checked 35 years later, when they averaged age 47, Vaillant reports that the children of poverty were now "almost indistinguishable from those without . . . initial disadvantages."

Both groups had been employed during more than 90 percent of their lives, both had very similar income levels and showed very little difference in criminal records or mental health.

Eighty to 85 percent of the children from poor, "multi-problem" homes escaped permanent poverty to the stable working class or above.

The University of Michigan data also show the obverse side of the poverty question: a significant percent of the poor move out of poverty, even to the highest income levels of society. But an almost exactly equal number of the rich and middle class slip down to the bottom of society.

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NATIONAL
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MAY 10 1984

May 7, 1984

Hon. Charles E. Grassley
Chairman, Subcommittee on Aging
Committee on Labor and Human Resources
Senate Office Building
Washington, D. C. 20510

Dear Senator:

I have your letter of April 23 asking that we reply to the following questions for the hearing record:

> "The number of job slots available to this program nationally is 62,500. Do you have figures for how many people actually are enrolled in the program on an annual basis? And do you have figures on the length of time individuals reamin in the program?
>
> "What I am trying to get at here is whether we are paying for a fairly stable pool of people in this program or whether there is some turnover so that other people have opportunities to participate? Does your organization keep any figures which would help us get a handle on this?"

I want to note for the record that National Farmers Union acts as sponsor for Green Thumb, Inc. a 501-c-(3) non profit organization chartered in the District of Columbia which contracts with the Department of Labor to administer funds from Title V of the Older Americans Act, the Senior Community Service Employment Program with some 9,000 host agencies in rural communities in 45 states and Puerto Rico.

I have conferred with Green Thumb staff at the national office and am happy to relay the following information in reply to your questions.

The total number of funded authorized positions for Green Thumb during the July 1983 - June 1984 grant year is 17,317. The current number enrolled is 18,941. The total number served in the in the 9 month period between July 1983 and March 31, 1984 has been 24,475. Thus, 41 percent more persons were served over the base authorized positions.

There has been a turnover of 5,534 enrollees for the same period or 32 percent of the authorized positions. Placement into unsubsidized employment accounted for 2,038 of the terminations, or 12 percent. About 122 of those placed returned to the program after their unsubsidized jobs did not work out.

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In reviewing the placement of enrollees who had left the program to move into unsubsidized employment, we found that 40 percent obtained jobs in private industry, 37 percent were hired by their host agencies, 14 percent found jobs in other public agencies and 9 percent became self employed.

Fifty-one percent of the enrollees leaving the program found full time work and 49 percent obtained part time jobs. The rates of pay varied. Over 82 percent received higher than the minimum wage and 17 percent of these received more than $5.00 per hour after placement.

It was found after the 3 month follow-up by Green Thumb staff that an average of 75 to 80 percent of the enrollees remain employed in their new jobs.

Reports on the length of time each enrollee is on the program are not kept since the regulations do not place a limit on the time a person may be enrolled. Information available on the length of time that persons are enrolled prior to being placed in unsubsidized employment reveals that 67 percent of the people placed were on the program for less than one year.

As you know, Senator, funds for Title V are distributed to the states on a formula which includes several factors. Within the state, the state administrators of funds and representatives of the governor, often through the state agency on aging meet to work out equitable distribution of funds within the state, based on available substate statistics. The formula for distribution of slots within the states, when applied properly is quite equitable, it is felt, and has been working adequately for the past several years.

We hope this information is useful to your Committee and to the Senate in their deliberations on the Older Americans Act Amendments. Please call on us if further information would be useful.

Kindest personal regards.

Sincerely,

Ruth

Ruth E. Kobell
Legislative Assistant

Senator GRASSLEY. Thank you.

Mr. Reilly.

Mr. REILLY. Mr. Chairman, the National Council on the Aging is pleased to present our recommendations on reauthorization of the Older Americans Act. My name is Donald Reilly. I am deputy executive director of NCOA.

NCOA is vitally interested in each of the titles of the Older Americans Act. Therefore, I will submit for the record our position paper on reauthorization. It contains an analysis of significant issues in each of the titles of the act, and recommendations for dealing with them.

The paper sets forth the views of the National Council on the Aging and its seven constituent membership groups: the National Institute of Senior Centers, the National Institute on Adult Day Care; the National Institute an Community-Based Long-Term Care; the National Association of Older Worker Employment Services, the National Institute of Senior Housing, the National Center of Rural Aging; and the National Voluntary Organizations for Independent Living for the Aging.

[The following was received for the record:]

THE NATIONAL COUNCIL ON THE AGING, INC.
Since 1950 working to improve the lives of older Americans
600 MARYLAND AVE., SW • WEST WING 100 • WASHINGTON, DC 20024 • TELEPHONE (202) 479-1200

February 1, 1984

RECOMMENDATIONS ON THE 1984 REAUTHORIZATION OF THE OLDER AMERICANS ACT

BY THE NATIONAL COUNCIL ON THE AGING, INC.
AND ITS CONSTITUENT MEMBERSHIP GROUPS

o NATIONAL INSTITUTE ON ADULT DAYCARE
o NATIONAL INSTITUTE OF SENIOR CENTERS
o NATIONAL ASSOCIATION OF OLDER WORKER EMPLOYMENT SERVICES
o NATIONAL INSTITUTE OF SENIOR HOUSING
o NATIONAL CENTER ON RURAL AGING
o NATIONAL VOLUNTARY ORGANIZATIONS FOR INDEPENDENT LIVING FOR THE AGING

GENERAL COMMENTS

NCOA strongly believes that the Older Americans Act, and the activities carried out under the Act, have been beneficial for many older persons. As the greying of America continues, it is important to reaffirm support for the Act and the programs it authorizes.

We see no need for major changes in the Act at this time. What is needed is adequate funding for the complex and difficult program responsibilities set forth in the Act, plus the vigorous, creative, cooperative, and effective carrying out of those responsibilities by public and private organizations at the federal, state and local levels. Our recommendations are targeted at maintaining the continuity of approach set forth by the statute, the current regulations, and Congressional committee reports, while clarifying areas in which varying interpretations of Congressional intent have caused difficulties.

The programs under the Act should be extended for five years, through fiscal 1989. Assured stability and continuity is critical so that there is an incentive to work on long term as well as short term advocacy and service system delivery activities. In any case reauthorization should be for no less than three years.

The appropriations authorized for fiscal 1985 onward should reflect the continued rapid growth of the older population, and the fact that there is not one community in the nation that has a truly comprehensive and coordinated system of services and opportunities for older persons. Thus, the Older Americans Act programs are not "mature" in the sense of having substantially achieved the program goal. They are still evolving to meet the challenge posed by the rapid growth in numbers of the elderly, and particularly the growth in numbers of the "old-old" population.

President **Arthur S. Flemming, J.D.**; Vice Presidents **Anna V. Brown, James T. Sykes**
Secretary **Edith Sherman, Ph.D.**; Assistant Secretary **Barbara Sklar**; Treasurer **James H. Agee**; Assistant Treasurer **Roger A. Baird**
Executive Director **Jack Ossofsky**

TITLES I, II, III, VI

Titles I, II, III, and VI of the Older Americans Act comprise an almost unique piece of legislation. Most human services legislation provides for the establishment and administration of a particular program or programs. However, the structure and interrelatedness of these titles covers a much wider area. It is important to review the central themes they set forth

Title I of the Act sets forth a declaration of 10 broad spectrum objectives for older Americans which cover almost the whole range of issues and programs which affect older persons. Title II charges the Commissioner on Aging and the Administration on Aging to:

- "serve as the visible and effective advocate for the elderly within the Department of Health and Human Services, and with other departments, agencies and instrumentalities of the Federal Government by maintaining active review and commenting responsibilities over all Federal policies affecting the elderly";
- "develop and operate programs providing services and opportunities as authorized by this Act which are not otherwise provided by existing programs for older individuals";
- "develop basic policies and set priorities with respect to the development and operation of programs and activities conducted under authority of the Act"; and
- "coordinate and assist in the planning and development by public (including Federal, State and local agencies) and private organizations or programs for older individuals, with a view to the establishment of a nationwide network of comprehensive, coordinated services and opportunities for such individuals."

In Title III of the Older Americans Act, there has been a Congressional focus on state and area agencies on aging carrying out, at their respective levels, the same, very complex roles: advocacy on behalf of the elderly across the spectrum of issues, programs, and policies that impact on older persons; and leadership in the development, at the community level, of comprehensive and coordinated service delivery systems for older persons which include all public and private agencies and resources. Title VI provides for the same functions, directed to Indian Tribes.

Over the years since enactment of the original legislation in 1965 there has been continuing tension between the Congress and the Executive Branch as to the degree to which these roles, particularly the advocacy role, would be carried out. Many of the advocacy and service system development functions cut across the grain of the typical functional organization structures at the federal, state, and local levels. This has created frictions in some cases, ignoring of assigned roles in other cases. The Congressional response has been periodic amendments to the Act, which have made more specific the nature of the roles to be carried out, the administrative structure, and the processes.

The wholesale repeal of existing regulations proposed in the Federal Register Notice of Proposed Rulemaking (NPR) issued by the Administration on Aging on March 2, 1983 would have created a substantive retreat from the role assigned to the Commissioner by Title II, to "develop basic policies and set priorities with respect to the programs and activities conducted under the Act." The NPR also proposed deletions which would have restricted representation of the elderly in the planning and operation of the programs, and withdrawn important advocacy and service delivery systems development provisions. As pointed out to the Commissioner on Aging in letters from both the Senate and House Committees on Aging, the proposed deletions would be violations of Congressional intent. Therefore, the 1984 Amendments to the Act should increase the clarity of legislative intent by incorporating into the Act many of the regulatory provisions that were proposed for deletion, and reaffirm in Committee reports the intent that the others shall be retained in the regulations.

In most other human services programs, the state or local recipient of the federal funds is the service provider. Here again, Title III strikes off on a very different path. In conformity with the assignment of advocacy and service system development roles to the state and area agencies, Title III provides "that no supportive services, including nutrition services, will be directly provided by the State agency or an area agency, except where, in the judgment of the State agency, provision of such services by the State agency or an area agency on aging is necessary to assure an adequate supply of such services."

Title III then identifies building blocks toward the development of comprehensive and coordinated service systems for older persons in the communities by providing that area agencies shall:

- "designate, where feasible, a focal point for comprehensive service delivery in each community to encourage the maximum collocation and coordination of services for older individuals, and give special consideration to designating multipurpose senior centers as such focal point;" and

- "The Commissioner shall carry out a program for making grants to States under State plans approved under Section 307 for the acquisition, alteration, or renovation of existing facilities, including mobile units, and, where appropriate, construction of facilities to serve as multipurpose senior centers which shall be community facilities for the organization and provision of a broad spectrum of services, including provision of health, social, nutritional, and educational services and provision of facilities for recreational activities of older individuals" - "Funds made available to a State under this part may be used for the purpose of assisting in the operation of multipurpose senior centers, to meet all or part of the costs of compensating professional and technical personnel required for the operation of multipurpose senior centers."

Title III also provides, in Parts B and C, for the funding of a wide variety of supportive services such as information and referral, legal services, transportation, health screening, housing services, congregate and home delivered meals, and "any other services" --- which "are necessary to the general welfare of older individuals."

Thus, the overall concept is clearly one in which the funding by area agencies is to promote coordination and collocation of services, and to help service providers meet the needs of older persons which are not met by other public and private funding streams.

Adherence to this overall concept has varied from state to state and area to area. This has hampered cooperative relationships and progress toward the Title III goal of development of comprehensive, coordinated service delivery systems for older persons. The 1984 amendments should reaffirm and strengthen the overall concept and its interrelated elements.

A continuing ambiguity is attached to the concept of the national network on aging. The National Association of State Units on Aging, under a cooperative agreement with the Administration on Aging, issued "An Orientation To The Older Americans Act" in May of 1982. It contained a chart in Appendix B labeled "The National Aging Network." It showed the network being made up of AoA, state and area agencies on aging, and local service providers, as well as the Federal Council on Aging, national aging organizations and their state and local counterparts, and research and education programs focussed on aging. NCOA supports this view. However, AoA documents and staff occasionally refer to the network as composed only of AoA and the state and area agencies, and this view is reflected in some state and area agencies.

The difference in definition is important. The first definition suggests a cooperative network which recognizes the governmental and private sector pluralism which must be linked together to effectively meet the needs of the elderly. It also implies that the advocacy and service delivery system building responsibilities are also shared at the service provider - grantee contractor level in this program. In addition to reflecting reality, this approach should protect the Title III and V grantees from OMB imposed limitations on their advocacy activities on behalf of older persons. The AoA-state-area agency definition undercuts the broad-spectrum system development concept in the Act, and ignores the advocacy role of service providers and other aging organizations on behalf of their clients. A definition of the national network on aging should be added to Title III to resolve this ambiguity.

RECOMMENDATIONS

Role of the Commissioner on Aging

1. The position of Commissioner on Aging should be raised to Assistant Secretary on Aging. The cross-program and cross-agency advocacy and system building roles assigned to the Commissioner by the Congress in Title III go far beyond the scope normally associated with a fourth level Department position.

The greater level of visibility and authority at the Assistant Secretary level are important levers to use in carrying out these roles. Further, establishment at the Assistant Secretary level would preclude the periodic encroachments upon the authorities conferred upon the Commissioner by the statute which have occurred under several national Administrations by successive Assistant Secretaries for Human Development Services. (Recent reports by the General Accounting Office illustrate this problem.)

2. The statute has never made an explicit connection between the Declaration of Objectives set forth in Title I and the advocacy role of the Commissioner on Aging. We recommend that this anomaly be resolved by amending Section 202(a) as follows:

> "Section 202(a). It shall be the duty and function of the Assistant Secretary on Aging AND Administration to - *
> (1) serve as the effective and visible advocate for the elderly, AND THE TEN OBJECTIVES SET FORTH IN TITLE I, within ------."

3. The role of the Commissioner in moving toward "--the establishment of a nationwide network of comprehensive, coordinated services and opportunities--" stated in Section 202(a)(12) requires the close coordination of community health and social services. This is true both for preventive services and community-based long term care. Therefore, Title I, Objective (8) should be modified by adding the word "health", as follows:

"(8) Efficient community services, including access to low-cost transportation, which provide a choice in supported living arrangements, AND HEALTH and social assistance in a coordinated manner and which are readily available when needed;"

Federal Council on the Aging

The provisions of Section 204(a) which govern membership on the Council should be amended to require the inclusion of persons from minority ethnic groups.

Incorporation of Regulations Into the Act

The March 2, 1983 Notice of Proposed Rulemaking proposed deletion of 92 of 134 existing regulations which the Congress had accepted since their publication after the 1973, 1975 and 1978 amendments as legitimate and appropriate explanations of Congressional intent. The loss of these provisions would gut the elements of advocacy, participation by the elderly in program development, and clear assignment of responsibility which are central to the concept of Title III. We strongly recommend that the Congress add provisions to the Older Americans Act for:

o clarifying that the "sole state agency" and the area agency on aging must be either a single purpose agency or a single organizational unit of a multi-purpose agency;

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* Legislative language set forth in capital letters in this and subsequent recommendations is a proposed addition.

- public hearings on the needs of older persons by the state agencies and area agencies;
- public hearings on state and area plans;
- state agency advisory councils;
- a minimum of 50% membership on state and area advisory councils to be comprised of older persons (including recipients of services and those in the greatest economic or social need);
- affirmative action plans;
- a definition of "greatest economic need" as an income level at or below the poverty threshhold established by the Bureau of the Census;
- advocacy as a co-equal responsibility with service delivery system development for the Administration on Aging, State agencies and area agencies;
- appropriate private access to residents of long term care institutions by state and local long term care ombudsmen;
- legal services legislative representation, the setting of case priorities, involvement of the private bar, and
- qualified full-time director and staff to operate each state and area agency.

A copy of NCOA's letter of May 2, 1983 to the Commissioner on Aging is attached. It gives the rationale for each of these recommendations.

Definitions

Section 302 currently contains definitions useful for understanding the intent of Title III. However, the absence of important definitions, such as national network on aging, area agency, comprehensive service system, community focal point for service delivery, multipurpose senior center (definition located elsewhere in Title III), community long term care, and adult day care center have caused considerable confusion as to Congressional intent. NCOA recommends that Section 302 be restructured to include the following definitions:

1. Community based comprehensive and coordinated system ("Community-based" would be added to the title).

   The definition should be amended by adding

   "AND (D) INCLUDE ACCESS SERVICES, COMMUNITY SERVICES, IN-HOME SERVICES, AND SERVICES TO THE INSTITUTIONALIZED"

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2. National network on aging (new-to be derived from Section 202 (a)(12)), making clear that it includes all service providers and advocates)
3. State
4. State Agency on Aging
5. Planning and service area
6. Area Agency on Aging (new)
7. Unit of general purpose local government
8. Community focal point for comprehensive service delivery (new - to be derived from Section 306 (a)(3), clarifying that it is meant to be a place for coordinated service delivery and not another level of administration. We recommend transferring the following definition from the current regulations into the Act:

   "A FACILITY OR MOBILE UNIT WITHIN A DEFINED COMMUNITY WHICH PROVIDES OLDER PERSONS WITH MAXIMUM DIRECT ACCESS TO AVAILABLE SERVICES, IN A FASHION ACCEPTABLE TO THEM, BY ENCOURAGING CO-LOCATION AND COORDINATION OF SERVICES FOR OLDER INDIVIDUALS. MULTIPURPOSE SENIOR CENTERS SHALL RECEIVE SPECIAL CONSIDERATION FOR DESIGNATION AS SUCH FOCAL POINTS."
9. Multipurpose Senior Center (the definition is now mislocated in Section 321 (b)(1) - advocacy on behalf of older persons should be added to the definition.)
10. Information and Referral source
11. Legal Services
12. Community-based long term care (new)
13. Case Management (new)
14. Adult day care center (new)
15. Long term care facility
16. Education and training service

Targeting of Resources

There have been suggestions from some quarters that the targeting of Title III resources should be narrowed to the frail elderly in need of community long-term care. NCOA opposes this view because we are convinced that services which

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promote social interaction and community involvement serve a preventive function which often precludes or delays the need for community long term care. Therefore, we favor a Title III continuum of opportunities, services, and care to meet the spectrum of needs presented by older persons.

The 1982 Civil Rights Commission report, and earlier studies for the Administration on Aging, make it clear that older minorities are generally not served in relation to their needs for services. This varies from state to state and area to area but the overall situation requires that it be addressed in the statute. We believe that the Section 306(a)(5)(A) preference language should be amended, to add after "--greatest economic or social needs"

> ", WITH SPECIAL ATTENTION TO THE LOW INCOME, IMPAIRED, ISOLATED, LIMITED ENGLISH SPEAKING, AND A PARTICULAR FOCUS ON MEETING THE NEEDS OF MINORITY MEMBERS OF EACH OF THESE GROUPS--".

In relation to services for minority groups, the Committee reports should emphasize an intent that services should be provided in accordance with the degree of need for services, rather than reflecting the proportion of minority in the population.

Intrastate Funding Formula

We are concerned, however, that the requirement in Section 305 (a)(2)(C) for states to develop a formula for distribution within the state of funds received under this title and to "publish such formula for review and comment" does not necessarily provide an intelligible basis for analysis of the formula's impact on various communities. We support the Federal Council on Aging's recommendation of the following insertion in Section 305(a)(2)(c) after "--and comment"

> "THE PRESENTATION AND PUBLIC REVIEW AND COMMENT SHALL INCLUDE:
>
> (1) A DESCRIPTIVE STATEMENT OF THE FORMULA'S ASSUMPTIONS AND GOALS, AND DEFINITIONS OF "GREATEST ECONOMIC OR SOCIAL NEED";
>
> (2) AN ARITHMETIC STATEMENT OF THE ACTUAL FUNDING FORMULA TO BE USED
>
> (3) A LISTING OF THE POPULATION, ECONOMIC AND SOCIAL DATA TO BE USED TO IMPLEMENT THE INTRASTATE FUNDING FORMULA FOR EACH PLANNING AND SERVICE AREA IN THE STATE; AND
>
> (4) A DEMONSTRATION OF THE ALLOCATION OF FUNDS, VIA THE FUNDING FORMULA, TO EACH PLANNING AND SERVICE AREA IN THE STATE."

Provision of Services

NCOA strongly supports continuing the current State plan provision in Section 307(a)(10) -"provide that no supportive services, including nutrition services, will be directly provided by the State agency or an area agency on aging, except where, in the judgment of the State agency, provision of such services by the State agency or an area agency on aging is necessary to assure an adequate supply of such services". The planner-catalyst-coordinator advocate roles of the state and area agencies becomes much less credible if they are simultaneously competitors with non-profit service provider agencies.

Community Focal Points

A concern which pervaded the committee reports on initial passage of the Older Americans Act was to prevent fragmentation of services as the kind and number of services for older persons increased. This concern has been repeated in subsequent committee reports and is reflected in the emphasis in Title III on "coordinated" services. The concept of "a focal point for comprehensive service delivery in each community to encourage the maximum collocation and coordination of services for older individuals", as set forth in Section 306(a)(3) is critical to the success of the Title III program. The statutory language is clear. However, a variety of institutional pressures have tended to counter this emphasis on coordination. The Committee reports should emphasize continuing Congressional support for the further implementation of the "one-stop service center" concept.

Multipurpose Senior Centers

There has been some confusion in the states and at the local level as to the interpretation of Section 321(b)(1) and (2) and its relationship to the listing of services set forth in Section 321(a). NCOA strongly recommends the following revisions in order to clarify Congressional intent.

o Move the definition of multipurpose senior center from its present location as a subordinate clause in Section 321(b)(1) to the list of definitions in Section 302.

o Parallel the structure of Title III Part C in Title III Part B, by inserting the heading "Subpart 1-Supportive Services" above Section 321(a) and inserting "Subpart 2-Multipurpose Senior Centers" above the present Section 321(b).

o Amend the present Section 321(b)(1) and (2) into a new Section 322 which should make clear that the award of Older Americans Act funds for senior center core operations and senior center service delivery is not contingent upon a prior award of alteration or construction funds. We recommend the following language for Section 322:

"SECTION 322(a) FUNDS MADE AVAILABLE UNDER PART B THROUGH GRANTS TO STATES UNDER STATE PLANS APPROVED UNDER SECTION 307 MAY BE USED

(1) FOR THE COSTS OF OPERATING A MULTIPURPOSE SENIOR CENTER (SUCH AS STAFF, EQUIPMENT, UTILITIES, MAINTENANCE, REPAIRS, ETC); AND

(2) FOR THE RENOVATION, ALTERATION, EXPANSION, OR ACQUISITION OF EXISTING FACILITIES, INCLUDING MOBILE UNITS, AND, WHERE APPROPRIATE, CONSTRUCTION OF FACILITIES TO SERVE AS MULTIPURPOSE SENIOR CENTERS.

SECTION 322(b) AWARDS OF FUNDS TO SENIOR CENTERS FOR SERVICE DELIVERY AND ADVOCACY UNDER PART B1 SUPPORTIVE SERVICES, C1 CONGREGATE NUTRITION SERVICES, AND C2 HOME DELIVERED NUTRITION SERVICES SHALL NOT BE CONTINGENT ON A PRIOR OR CONCURRENT AWARD FOR RENOVATION, ALTERATION, EXPANSION, ACQUISITION, OR CONSTRUCTION OF THE FACILITY.

To conform to the clarifying language set forth above, Section 306(a)(1) should have a related phrase added as follows:

"(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance or construction of multipurpose senior centers TO PROVIDE SUCH SERVICES AND ADVOCATE ON BEHALF OF OLDER PERSONS within the planning and service area covered by the plan. -------"

Case Management

Case management is emerging as an increasingly important service for impaired and frail elderly persons who need multiple services which are difficult to coordinate. Many such older persons who live alone, or whose family members are unable to cope with the service coordination difficulties, can be maintained in their homes by effective case management. (See recommendation under Adult Day Care).

Adult Day Care Centers

Adult day care centers are a newly emerging and rapidly growing service. The centers, by providing group day care programs for impaired and frail older persons, permit working families to continue to maintain elderly relatives in their homes.

NCOA recommends that Section 321(a)(5) be amended as follows:

"(5) services designed to assist older individuals in avoiding institutionalization, including preinstitution evaluation and screening, and CASE MANAGEMENT, ADULT DAY CARE CENTER SERVICES, home health services, homemaker services, shopping services, escort services, reader services, letter writing services, and other similar services designed to assist such individuals to continue living independently in a home environment;"

Advocacy

Most non-profit agencies serving older persons consider advocacy on behalf of their clientele as important as service delivery. The successive revisions

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to OMB Circular A-122 proposed by the Office of Management and Budget have threatened the ability of Older Americans Act grantees to continue to advocate for older persons. The specific advocacy role of state and area agencies is set forth in the Act. This will protect them from being precluded from advocacy by whatever final revisions are made to A-122. A similar advocacy role for Title III, IV, V and VI grantees should be placed into the statute.

20% Funding Flexibility

NCOA recommends maintaining the provision which allows up to a 20% transfer between Parts B and C of Title III. This provision should provide adequate flexibility for state and area agencies to meet special circumstances.

USDA Commodities

The Administration has proposed cashing out and capping the current supplementation of the Part C1 and C2 nutrition services by commodities, or their equivalent in cash, from the Department of Agriculture. The capped amount would be included in the AoA budget and distributed to States under the Title III formula. The current practice is reimbursement by USDA based on the number of meals served. This system provides an incentive to meal service providers to adopt efficient practices, and to seek additional funds beyond those provided under Title III. The current provisions should be retained.

Federal Agency Consultation

Community Service Block Grants should be added to Section 203(b) (The Office of Community Services, the administrator of the Community Service Block Grants is already cited in Section 301(b)(2) for technical assistance and cooperation). The Job Partnership Training Act should replace the listing of the Comprehensive Employment and Training Act.

Evaluation

We believe that the amount of Older Americans Act funds authorized for use by the Secretary is too high. The authorization to use "--not to exceed 1 per centum of the funds appropriated under this Act, or $1,000,000, whichever is greater, to conduct program and project evaluations--" was placed in the Act when the level of appropriations under the Act was much lower. Also, in some cases the evaluation funds have been used for purposes of marginal relevance to the Older Americans Act programs. Section 206(g) should be revised to read "--not to exceed $1,000,000 of the funds appropriated under this Act to conduct program and project evaluations--".

TITLE V

The Older Americans Community Service Employment Program successfully promotes useful part-time opportunities in community service activities for unemployed low-income persons who are 55 years old or older. It is administered by the Department of Labor through national contractors and the states. The Administration has proposed transferring the program to the Department of Health and Human Services -Administration on Aging and eliminating the national contractors, who serve a majority of the current enrollees. The rationale given is that the Older Americans Act is administered by the Administration on Aging, other than Title V, and that the transfer will facilitate coordination of services in the communities.

Title V is one of many service and opportunity programs for older persons which are administered by agencies which specialize in their respective areas. Other examples are the Older Americans Volunteer Program - administered by the ACTION agency; health services administered by the Public Health Service; health care payment - administered by the Health Care Financing Administration; 202 housing and related supportive services - administered by the Department of Housing and Urban Development; Social Security retirement payments - administered by the Social Security Administration; Food Stamps - administered by the Department of Agriculture; and supportive services provided through the Social Service Block Grants and Community Service Block Grants - administered by two other offices of the Department of Health and Human Services. The variety of federal programs serving the elderly in their communities, together with the variety of those that are funded by United Way, church groups and other private funding sources, is the reason that the Act directs the Commissioner and the Administration on Aging to "develop and operate programs providing services and opportunities as authorized by this Act which are not otherwise provided by existing programs for older individuals."

Since the focus of the Older Americans Act is upon the creation of community networks of comprehensive and coordinated services and opportunities for older persons, supported by this variety of public and private funding streams, it makes little sense to transfer one of these programs unless it is part of an overall plan for reorganizing all programs that serve the elderly. The federal expertise on employment program rests in the Department of Labor, not the Department of Health and Human Services. Evaluations of the current Title V program have cited exemplary operation by the national contractors. On the basis that no convincing rationale has been presented, and the concept that "if it is working well, don't fix it," the proposed transfer and change in method of operation should be rejected.

We also urge that the fiscal year 1984 authorization for Title V be increased $2.15 million, from $317.3 to $319.45 million. The Title V program is currently operating at the $319.45 million level for the 1983/84 program year because the Emergency Jobs Act (P.L.98-8) provided for an increase above the authorized level. Unless the increase in the fy 1984 authorization is provided, the current scope of the Title V program must be reduced, beginning on July 1, 1984.

Title IV

The reduction in the funding of research, demonstration and training funds by 59% from fiscal year 1980 to 1984, ($54.3 million to $22.2 million) has been justified on the basis of maintaining community service levels. NCOA believes that the quality of services is as important as the quantity of ser-

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vices. Therefore, we believe that effective, short term, in-service training of service provider staffs, and the staffs of state and area agencies is of increasing importance in order to improve the quality of service delivery. At the same time, long-term career education programs must be maintained to complement in-service training since the number of elderly, and the "old-old" will continue to grow rapidly.

The necessary counterpart of training and education in assuring the quality of services is the development, and dissemination, of standards of service. This is an area which has received little attention so far under Title IV. It should become a funding priority, particularly in rapidly emerging areas of service such as adult day care, domiciliary care and in-home services, where the older person has little ability to "shop" among providers or to cope with the possibility of inept, or even abusive "caregivers". It is also important as a tool for the improvement of service quality in more established areas. The majority of service providers seek the development of such standards in order to improve or screen our low quality providers.

Analysis of the rapid changes in the demographics of the elderly population, the implications of these changes for service provision, policy analysis of emerging issues, research on techniques for coordination of services, and the identification and dissemination of service delivery models, self-help models, and models for involvement of the national voluntary agencies are all areas which are important to future success in developing community networks of comprehensive and coordinated services for older persons.

We believe that the research, demonstration and training programs are an integral part of the long-range design for developing these networks, not a separate competitive program within the Older Americans Act. Therefore, we continue to oppose reductions in the funding of these important elements of the overall aging program.

We recommend a statement of purpose for Title IV which states the interrelationship between the other Titles of the Act and Title IV, and the specific roles for research, demonstrations, training, education, and policy analysis.

We recommend deconsolidation of Title IV and specific authorizations so that the Congress can reassert its judgment as to the appropriate balance between the Title IV programs. We also support the prohibition against commingling of OAA Title IV funds with those of other programs.

SUMMARY

The Older Americans Act is a virtually unique statute constructed to help deal with a virtually unique national transformation, the greying of America. It is needed now. It will be needed more in the future. NCOA believes that our recommendations will help maintain and strengthen this important law.

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Mr. **Reilly**. Before turning to title V, I want to call your attention to several concerns relating to other titles. I will deal with each one very briefly, since our position paper will provide additional information.

In titles I and II, the statute has never made an explicit connection between the declaration of objectives set forth in title I and the advocacy role of the Commissioner on Aging and the Administration on Aging. We recommend that the statute be amended to make this connection clear. We also recommend that the importance of the Commissioner on Aging's advocacy role be reinforced in the committee report.

Title III: the March 2, 1983, notice of proposed rulemaking would have deleted 92 of 134 existing regulations. The Congress has accepted those regulations since their publication after the 1973, 1975, and 1978 amendments as legitimate, appropriate explanations of congressional intent.

The loss of these provisions would permit the gutting of the elements of advocacy, participation by the elderly in program development, and clear assignment of responsibility for program operation which are central to title III. We urge that the Congress add provisions to the act which will protect these key program elements.

The Congress has developed a highly innovative program structure in title III. The focus is on the Administration on Aging, the State units and the area agencies carrying out, at their respective levels, two very complex but interrelated roles.

One is advocacy on behalf of the elderly across the spectrum of issues, programs and policies that impact on older persons. The other is leadership in the development, in each community, of a comprehensive and coordinated service delivery system for older persons, which includes all public and private agencies and resources.

The Congress should keep this focus on the two roles. The limitations on direct service delivery by State and area agencies on aging should be retained. The provision for designation in each community of a community focal point for service delivery, with special consideration given to multipurpose senior centers for such designation should also be retained; and reemphasized in the committee report as a means of preventing fragmentation of services.

There have been suggestions from some quarters that the targeting of title III should be narrowed to the frail elderly in need of community long-term care. NCOA opposes this view because we are convinced that services which promote social interaction and community involvement serve a preventive function which often precludes or delays the need for community long-term care. Therefore, we favor a title III continuum of opportunities, services and care to meet the spectrum of needs presented by older persons.

Title IV: we strongly believe in the need for continuing research, policy analysis, training and career education. The extremely low appropriation requests by the administration for this title have indicated a disregard for the importance of these areas. We recommend authorizations higher than the current operating levels.

Title V: NCOA is proud to be one of the original group of national sponsors which proved the viability of the Senior Community Service Employment Program.

The program provides many benefits. Community service agencies gain additional staff to help them provide needed services. Low-income older persons who have not been able to get jobs are provided part-time employment through which they can increase their incomes and have the satisfaction of contributing to the well-being of others. Many of these older workers are placed into unsubsidized jobs in the private sector. This puts them back into the general work force and makes room in the program for additional low-income older persons who have not been able to find employment.

It is a program that works effectively under the present management structure. In support of this view, I will quote from the March 17, 1981 testimony of former Assistant Secretary of Labor Angresani before a House subcommittee:

> The SCSEP remains one of the Department's most visible efforts on behalf of older workers. Other Department programs surely affect older workers, but none command the visibility or the attention of SCSEP because of its singular focus and thrust to assist older workers.
>
> In addition, SCSEP has been void, in general, of fraud and abuse. We are also pleased with the performance of the national sponsors, who continue to enrich the program with their 12 years or more of experience.
>
> In summary, SCSEP has had a degree of favorable reception because it is a simple program, unburdened with complicated and voluminous regulations and reporting requirements, and because it remains flexible enough for program sponsors to accommodate the needs of both enrollees and their communities.

A management study was conducted by Morgan Management. That has been alluded to already. I will just quote the leader of that study, who cited as his personal opinion: "The SCSEP is the most effective program I have ever evaluated, and in my opinion it should be retained and strengthened."

There has been a proposal to transfer the program from the Department of Labor to the Department of Health and Human Services. There is a new proposal to shift only the portion of the program operated by the State units. In our opinion, neither proposal deserves further consideration. They are unjustified attempts to rearrange the inner workings of a program that is performing very, very well.

Reorganizations usually result in a decline in performance even in problem programs. Therefore, reorganization in a program that is very successful makes little sense, especially when the Federal expertise in employment programs rests in the Department of Labor, not in the Department of Health and Human Services.

[The prepared statement of Mr. Reilly and responses to questions submitted by Senator Grassley follow:]

THE NATIONAL COUNCIL ON THE AGING, INC.
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TESTIMONY ON REAUTHORIZATION
OF THE
OLDER AMERICANS ACT

To A Hearing Of
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON AGING

by
THE NATIONAL COUNCIL ON THE AGING, INC.

Presented by
Donald F. Reilly
Deputy Executive Director

March 13, 1984

President **Arthur S. Flemming, J.D.**; Vice Presidents **Anne V. Brown, James T. Sykes**
Secretary **Edith Sherman, Ph.D.**; Assistant Secretary **Barbara Sklar**; Treasurer **James H. Agee**; Assistant Treasurer **Roger A. Baird**
Executive Director **Jack Ossofsky**

Mr. Chairman, the National Council on the Aging is pleased to present our recommendations on reauthorization of the Older Americans Act. My name is Donald F. Reilly. I am Deputy Executive Director of the National Council on the Aging, Inc. Prior to this position I was the Deputy Commissioner of the U.S. Administration on Aging.

NCOA is vitally interested in each of the titles of the Older Americans Act. Therefore, I will submit, for the record, our position paper on reauthorization. It contains an analysis of significant issues in each of the titles of the Act and recommendations for dealing with them. The paper sets forth the views of the National Council on the Aging, Inc., and its six constituent membership groups; National Institute of Senior Centers, National Institute on Adult Day Care, National Association of Older Worker Employment Services, National Institute of Senior Housing, National Center on Rural Aging, and National Voluntary Organizations for Independent Living for the Aging.

Before turning to Title V, I want to call your attention to several concerns relating to the other titles. I will deal with each one very briefly, since our position paper will provide additional information.

Titles I - II

The statute has never made an explicit connection between the Declaration of Objectives set forth in Title I and the advocacy role of the Commissioner on Aging. We recommend that the statute be amended to make this connection clear. We also recommend that the importance of the Commissioner on Aging's advocacy role be reinforced.

TITLE III

The March 2, 1983 Notice of Proposed Rulemaking would have deleted 92 of 134 existing regulations which the Congress had accepted since their publication after the 1973, 1975 and 1978 amendments as legitimate and appropriate explanations of Congressional intent. The loss of these provisions would permit the gutting of the elements of advocacy, participation by the elderly in progam development (through advisory committee membership and public hearings on state and area plans), and clear assignment of responsibility for program operation which are central to the concept of Title III. We urge that the Congress add provisions to the Act which will protect these key program elements.

The Congress has developed a highly innovative program structure in Title III. The focus is on the Administration on Aging, the state units, and the area agencies on aging carrying out, at their respective levels, two very complex, but interrelated, roles. One is advocacy on behalf of the elderly across the spectrum of issues, programs, and policies that impact on older persons. The other is leadership in the development, at the community level, of comprehensive and coordinated service delivery systems for older persons, which include all public and private agencies and resources. The Congress should keep this focus by retaining the limitations on direct service delivery by state and area agencies on aging; and by reemphasizing the need to prevent fragmentation of services by designation, in each community, of a community focal point for service delivery, with special consideration given to multipurpose senior centers for such designation.

There have been suggestions from some quarters that the targeting of Title III resources should be narrowed to the frail elderly in need of community long term care. NCOA opposes this view because we are convinced that services which promote social interaction and community involvement serve a preventive function which often precludes or delays the need for community long term care. Therefore, we favor a Title III continuum of opportunities, servics and care to meet the spectrum of needs presented by older Americans.

TITLE IV

We strongly believe in the continuing need for research, policy analysis, demonstration projects, in-service training, and career education. The authorizations should reflect these needs. We also strongly believe that Title IV funds should be addressed to an important area that has received little attention to date, the development and dissemination of standards for specific services. Such standards are particularly needed in rapidly emerging areas of service such as adult day care, domiciliary care, and in-home services. Standards are also important as a tool for the improvement of service quality in more established areas.

TITLE V

NCOA is proud to be one of the original group of national sponsors which proved the viability of the Senior Community Service Employment Program. The program provides many benefits: community service agencies gain additional staff to help them provide needed services; low-income older persons who have not been able to get jobs are provided part-time employment through which they can increase their incomes, and have the satisfaction of contributing to the well being of others; and many of these older workers are placed into unsubsidized jobs in the private sector, which puts them back into the general work force and makes room in the program for additional low-income older persons who have not been able to find employment.

It is a program that works effectively under the present management structure. In support of this view, I will quote from the March 17, 1981 testimony of former Assistant Secretary of Labor Angrisani before a House Subcommittee:

"... the SCSEP remains one of the Department's most visible efforts on behalf of older workers. Other Department programs --- surely affect older workers, but none command the visibility or the attention of SCSEP because of its singular focus and thrust to assist older workers. In addition, SCSEP has been void in general of fraud and abuse. -- We are also pleased with the performance of the national sponsors, who continue to enrich the program with their 12 years or more of experience. -- In summary, SCSEP has had a degree of favorable reception because it is a simple program, unburdened with complicated and voluminous regulations and reporting requirements, and because it remains flexible enough for program sponsors to accomodate the needs of both enrollees and their communities."

A management study of SCSEP was conducted in 1981 by Morgan Management Systems for the Federal Council on Aging. The study leader, Soloman Jacobson, testified before another House subcommittee on February 25, 1982. He said "We found the SCSEP to be an effective program. -- There has been cooperation among national sponsors and state sponsors to the benefit of the older workers served by the program. -- The SCSEP is the most effective program I have ever evaluated, and in my opinion it should be retained and strengthened."

There has been a proposal to transfer the Title V Senior Community Service Employment Program from the Department of Labor to the Department of Health and Human Services and terminate the natijonal sponsors. There is a more recent Administration proposal to only transfer the funds for State Agency sponsor operations to the Department of Health and Human Services. The two statements quoted above, one from a former Assistant Secretary of Labor in this Administration, and the other from a professional evaluation company, show why both proposals should receive no further consideration. They are attempts to rearrange the inner workings of a program that is performing very well. Since reorganizations often result in a further decline in performance even in problem programs, reorganization of a program that is successful makes little sense, especially when the federal expertise in employment programs rests in the Department of Labor, not in the Department of Health and Human Services.

There have been statements made about poor coordination between national and staff sponsors. NCOA is proud of its working relationship with the states. For example, three states, New Jersey, Arizona and Florida award all or part of their state allotments to NCOA. We work with the states to improve the equitable distribution of slots within the states whenever additional funds become available, as in 1983 as a result of the Emergency Jobs Bill.

We are working on techniques to help improve the unsubsidized placement process. NCOA will publish a how-to handbook on starting and operating job clubs as a contribution to sharing good techniques. We will make this handbook available to both state and national sponsors.

The Section 502 demonstration projects to find new ways to train and place low-income older workers are working out well. Our projects, located in Vermont, New York, New Jersey, West Virginia, Ohio, Alabama, North Carolina, Tennessee and California are training older workers for new careers in growth industries, requiring adaptation of past skills to new technologies.

We see additional potential for unsubsidized placements as techniques improve. However, there are a variety of factors that impact on unsubsidized placement rates; the age of the enrollee, education level, skills level, geographical location of the project, and the economic conditions in the area. The Department of Labor target level of 15% unsubsidized placements seems designed to promote a balanced program which takes all of these factors into account. Our current placement rate is 18%.

In summary, Title V is a successful program; it helps local community service agencies; and it helps unemployed low-income older workers. It should be continued in its present form.

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That is my oral statement, Mr. Chairman. I urge your serious consideration to the additional recommendations made to improve the Act which are contained in our position paper. I will be pleased to respond to any questions that you may have.

QUESTION FOR DON REILLY FROM SENATOR CHARLES E. GRASSLEY

Turnover

For the year September 1, 1982 through August 31, 1983 NCOA had 5,129 enrollee slots. 7,840 enrollees participated in the program during the year.

Of the enrollees during that year, 48.6% were in the program for 12 months or less. The median stay in the program of enrollees who participated during that year was 12 months.

RESPONSE FROM DON REILLY TO QUESTION RAISED AT HEARING

Mr. Reilly. We are currently working on a report on our Section 502 demonstration projects. These projects involve the training and placement of low income older individuals in private industry jobs. The report will include information on the kinds of placements and subsequent job experience. The report will be submitted to the Department of Labor in September, 1984.

We are also in the process of developing a centralized management information system for the main NCOA-SCSEP program. We will use this system to generate a report on job experience after placement when the system is implemented.

Senator Grassley. Thank you.

Mr. Anderson.

Mr. Anderson. Thank you, Mr. Chairman. Thank you for the opportunity to appear before the subcommittee to describe the Forest Service's participation in the Title V program. We will limit our remarks to our role as a national sponsor of the program and defer to the representatives of the Department of Labor for the administration's views on the title V program.

The Forest Service has participated since the inception of this program. Our positions are constantly filled and we generally serve more than our authorized enrollment level of 4,128 positions.

Currently, the Forest Service conducts the SCSEP in 38 States, Puerto Rico, and the District of Columbia. We have approximately 800 projects which are administered within eight regions, nine forest and range experiment stations, and one area office.

The Forest Service directly administers its SCSEP and most projects are under the jurisdiction of Forest Service personnel. During the past year, we have been able to provide an average of 22 hours of employment, supplemental income, and training through the Senior Conservation Employment Program to approximately 5,107 low-income elderly persons predominantly residing in rural communities.

The 5,107 participants accomplished 2,189 years of work which was valued at $26.2 million. Approximately 35 percent were women and 21 percent were minorities. The majority of participants reside in communities where employment opportunities are very limited. The median age of our enrollees is between 60 and 64 years.

Most participants had educational levels below the eighth grade and 84 percent of the enrollees were economically disadvantaged.

In order to provide equitable distribution of program benefits, the Forest Service maintains liaison with other program sponsors, and we also coordinate program activities through the clearinghouse process to coordinate grants within each State.

Enrollees are used in all facets of the Forest Service mission. Typically, duties performed by the enrollees include maintenance and clean up of campgrounds; repair and maintenance of our field offices, work center grounds and other facilities; work on road and trail maintenance; sign replacement and repair; construction of stream structures and fish habitats; providing information to community residents about fire prevention; and the seeding and fertilization of wildlife openings. For the most part, the work has been labor-intensive and has supplemented work carried out under our regularly funded program.

The program has brought the Forest Service some highly skilled craftsmen who are dedicated to performing each task to the highest quality standard. We are pleased that the Forest Service has been able to provide a wide spectrum of services to our older American citizens.

That concludes my prepared remarks. I would be happy to answer the subcommittee's questions.

[The prepared statement of Mr. Anderson and responses to questions submitted by Senator Grassley follow:]

STATEMENT OF
LEON H. ANDERSON, DIRECTOR, HUMAN RESOURCE PROGRAMS,
FOREST SERVICE
DEPARTMENT OF AGRICULTURE

Before the
Subcommittee on Aging
Committee on Labor and Human Resources,
United States Senate

Concerning Title V of the Older Americans Act

March 13, 1984

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to appear before the Subcommittee to describe the Forest Service's participation in the Title V program. We will limit our remarks to our role as a National sponsor of the program and defer to the representative of the Department of Labor for the Administration's views on the Title V program.

The Forest Service refers to its Title V program as the Senior Conservation Employment Program (SCEP). The program is administered by the Agency under an Interagency Agreement with the United States Department of Labor. We believe that the SCEP has a three-fold purpose: (1) to provide useful part-time employment to the low-income elderly; (2) to provide participants with needed supplemental income; and (3) to provide training to participants through community service projects so that they may eventually return to the regular, competitive labor market.

The Forest Service has participated since the inception of this program. The level of funding for Fiscal Year 1983 was $21.1 million. Our positions are constantly filled, and we generally serve more than our authorized enrollment level of 4,128 positions. Currently, the Forest Service conducts the SCEP in

38 States, Puerto Rico and the District of Columbia. We have approximately 800 projects which are administered within eight regions, nine Forest and Range Experiment Stations and one Area office. The Forest Service directly administers its SCEP, and most projects are under the jurisdiction of Forest Service personnel. Generally, the Forest Service does not work with host agencies in operating the program. However, we have three small grants to State Foresters in Maine, New Hampshire, and Vermont which were originally negotiated under the Operation Mainstream Program.

During the past year, we have been able to provide an average of 22 hours of employment, supplemental income, and training through the Senior Conservation Employment Program to approximately 5,107 low-income elderly persons predominantly residing in rural communities. The 5,107 participants accomplished 2,189 years of work which was valued at $26.2 million. Approximately 35 percent were women and 21 percent were minorities. The majority of participants reside in communities where employment opportunities are very limited. The median age of our enrollees is between 60-64 years. Most participants had educational levels below the 8th grade and 84 percent of the enrollees were economically disadvantaged. In order to provide equitable distribution of program benefits, the Forest Service maintains liaison with other program sponsors, and we also coordinate program activities through the clearinghouse process to coordinate grants within each State.

Enrollees are used in all facets of the Forest Service mission. Typical duties performed by the enrollees include (1) maintenance and cleanup of campgrounds; (2) repair and maintenance of our field offices, work center grounds and other facilities; (3) work on road and trail maintenance; (4) sign replacement and repair; (5) construction of stream structures for fish habitats; (6) providing information to community residents about fire prevention; and (7) the seeding and fertilization of wildlife openings. For the most part, the work has been labor intensive and has supplemented work carried out under our regularly funded program.

The abilities of our seniors vary with their age, experience, and health. But one common thread that we have observed is the fundamental work ethic that many people say is less evident in our younger generations. Some of the benefits may be less tangible. We want to share some of these benefits with you.

One of the most exciting benefits we have observed is to see our SCEP enrollees working side by side with young people, ages 16 to 21, who are employed in other programs which we administer. These people, of entirely different generations, find common ground in spite of their age difference. The positive effect the older workers have on these young people is tremendous. Our young enrollees are learning to experience the same pride and satisfaction that our seniors derive from providing valuable service while earning a day's pay for a day's work. What might be less evident is the increased self esteem, improved physical health, and sustained mental capabilities that the Older American enrollees derive by being able to remain in the mainstream of activity. Under the Administration's proposed changes to the program, we would expect that these benefits would continue.

The program has brought the Forest Service some highly skilled craftsmen who are dedicated to performing each task to the highest quality standard. We are pleased that the Forest Service has been able to provide a wide spectrum of services to our older American citizens.

That concludes my prepared remarks. I would be happy to answer the Subcommittee's questions.

QUESTIONS FOR LEON ANDERSON FROM SENATOR CHARLES E. GRASSLEY

QUESTIONS AND ANSWERS

Question:	The number of job slots available in this program nationally is 62,500. Do you have figures for how many people actually are enrolled in the program on an annual basis? And do you have figures on the length of time individuals remain in the program?
Answer:	During July 1, 1982 to June 30, 1983, the USDA Forest Service Title V program had 3,331 authorized enrollment positions. Through effective and efficient management, we were able to enroll 5,107 persons. Placement and terminations totaled 1,117, representing a 22 percent turnover rate. We do not maintain records which would indicate the average length of time participants remain the program. The Forest Service conducts its Title V program predominantly in remote rural locations where employment opportunities are often limited. For this reason our program may have a more fairly stable pool of participants than program sponsors who operate in larger labor market areas.
Question:	With respect to the coordination issue, would the Forest Service support a change in the law which required the State plan developed by the State (agencies) on aging to include a plan for the Title V program?
Answer:	The Forest Service has actively participated in activities with national and State Title V sponsors to achieve an equitable distribution of employment positions. We believe that current equitable distribution State plans and coordination efforts are adequate.

Senator GRASSLEY. Mr. Hutton.

Mr. HUTTON. Thank you very much, Senator. My name is Bill Hutton. I am the executive director of the National Council of Senior Citizens, and have been so for the past 22 years.

For 16 years, the National Council has been a sponsor of the title V program; since its inception, actually. As one of the three original sponsors, we have seen the Community Service Employment Program grow from a $10 million demonstration project to a program that is expected to serve nearly 65,000 low-income elderly this fiscal year, with appropriated funds, I hope, of $319 million.

The expansion of title V over the years reflects the program's tremendous popularity in towns and cities across the country, and its unparalleled bipartisan support here in Washington.

Every independent study that has investigated title V has concluded that the program's management by the Department of Labor, through the eight national contractors and States, is cost-effective and free of abuse.

In over 16 years as a national contractor, for example, NCSC is proud of the fact that while we have continually worked to improve the program, we have also constantly sought ways to reduce Federal costs.

Although the law allows administrative costs of up to 15 percent, currently our administrative cost rate is less than 6 percent. This savings in administrative costs has enabled us to employ more than 1,000 additional older workers above our DOL-required levels.

The success of title V, moreover, can be attributed to the original concept that low-income older workers have a vital role to play in meeting local community needs. Our staff monitors job sites on a systematic basis to ensure that senior aides are employed in meaningful jobs and that they are providing communities with needed services.

State and local community service budgets have shrunk in recent years. The only way some needed services have been retained or new ones provided has been through the use of senior aides.

For example, the State of Michigan saw a dramatic escalation of hunger as a result of the recession and massive layoffs in the automobile industry. Senior aides in the Michigan project were used to initiate and staff a food distribution program that has delivered an average of 5 tons of meat, produce, and canned goods each week for the last 2 years. This is in addition to the distribution of USDA commodities.

The Title V Program has also helped senior aides obtain the experience, confidence, and job search skills needed to seek out employment not subsidized by the Government. Even with record high rates of unemployment particularly among older workers, we have seen an increase in the number of unsubsidized jobs senior aides have obtained.

In 1982, our unsubsidized placement rate was 11.8 percent. For the first two quarters of this year, that rate has increased to 15.3 percent.

Mr. Chairman, NCSC believes that proposals for structural revisions in the title V program—including shifting all or part of the program funds to the Department of Health and Human Services—

are unnecessary. They are disruptive and, we believe, a waste of taxpayer dollars.

There is no agency of the Federal Government that has more expertise in carrying out the objectives of this employment program than the Department of Labor, nor is there any indication that title V has not been effectively administered by DOL.

I would conclude by saying that additional comments can be found in my written testimony, Senator Grassley, and I do appreciate and understand the courtesy you have given to us at this time. And, of course, we do approve of the idea of good study into the effective operation of this important program.

Thank you.

[The prepared statement of Mr. Hutton and responses to questions submitted by Senator Grassley follow:]

Statement for the Subcommittee on Aging
Committee on Labor and Human Resources
U.S. Senate
Reauthorization of the Older Americans Act

William R. Hutton, Executive Director
National Council of Senior Citizens
925 15th Street, N.W,
Washington, D.C. 20005

March 13, 1984

Mr. Chairman, Members of the Committee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens.

The National Council of Senior Citizens is a non-profit, non-partisan organization representing over four million older people in over 4,500 clubs and area and state councils in all states. We welcome this opportunity to comment on the Older Americans Act. We believe that the need for a well-considered and adequately funded Older Americans Act has never been greater. A growing elderly population coupled with drastic reductions in Federal health and social service programs make it imperative that we take steps to ensure that the elderly's basic needs are met now and in the future.

Because of the enormous cuts in other programs that are of critical importance to the elderly, and because of the Act's documented success in meeting the day-to-day needs of so many older people, we believe that there should be no major changes in the Act, and that all the Act programs should be extended for a minimum of three years. As it now exists, the Act, for the most part, provides for the satisfactory administration of the various programs which provide the elderly with social, nutritional and employment services. Consequently, we do not believe it necessary, as has been proposed in the Administration's FY 85 budget, to consolidate Titles IIIB and C. Consolidation of Title III funds would be a disservice to the elderly. Such a move could weaken the individual programs, especially the vital nutrition programs. States would have too much flexibility in the allocation of funds; funds could be diverted to less important but perhaps more easily administered or less costly programs, and the elderly would be left without essential services. Neither do we believe it necessary to alter in any way the current structure of the Title V program.

We do have a few minor suggestions for the Act. First, we would like to see more funding for Title III programs. The Act should be funded so as to be able to service more elderly than it already does. For example, in 1982, the meals programs served over 172 million meals to senior citizens; however, thousands more were eligible for and in need of these meals. With increased funding for all Title III programs, the older population could better benefit from the one Federal program designed specifically to meet their social and nutritional needs. Second, we would like to see stronger language in the Act concerning priority services in Title IIIB. A more precise indication as to the amounts that must be spent on these areas should be included to ensure that some IIIB funds are, in fact, spent on in-home, access and legal services. It is our understanding, for example, that while legal services is a priority service, 17-20% of AAAs spend no money on legal services, and are in clear violation of the law. We believe that language concerning priority services should state that a specific percentage of IIIB funds must be spent on priority services.

Third, we urge the inclusion of additional and stronger language describing the advocacy role of the aging network. We believe the role of State and Area Agencies should not be limited only to being service providers and administrators. These agencies are in the position both to know the needs of the elderly and to be familiar with legislative and administrative processes. They should use this knowledge to be more outspoken on behalf of the elderly whenever possible. In a time of limited Federal, state and local resources, it is imperative that as many informed advocates as possible express the problems and needs of the elderly.

Fourth, there has been a concerted effort on the part of some meals providers to increase the amount of voluntary contributions received from participants in senior meals programs. This has led to some low-income senior citizens dropping out of much-needed programs due to embarrassment at their inability to pay. The Act should clarify that these contributions are strictly voluntary and that no one will be denied a meal because he or she cannot contribute.

Title IV is the one area we believe some corrective changes could be made. First, funding for Title IV should be raised to more adequate level. Title IV has been decimated by budget reductions in the past three years; yet, with the growing aging population, the need for further aging research and training have never been greater. Second, a statement of purpose for Title IV should be developed and Title IV should be deconsolidated to include separate program categories. The scope and purpose of each program should be spelled out with emphasis upon certain specific activities. The inclusion of a specific program that would provide for technical assistance and training to local legal services programs and the development of innovative legal service delivery methods is an example of the program that should be earmarked under Title IV. Third, the reporting requirements should be strengthened and AoA should submit a detailed annual report to Congress describing Title IV activities, projects and plans. At present, Congress is totally uninformed as to accomplishments achieved through Title IV.

The National Council of Senior Citizens has been a sponsor of the Title V since its inception sixteen years ago. As one of the three original sponsors, we have seen the Senior Community Service Employment Program grow from a $10 million demonstration project to a program that is expected to serve nearly 65,000 low-income elderly this fiscal year, with appropriated funds of $319.45 million.

The expansion of Title V over the years reflects the program's tremendous popularity in towns and cities across the country and its unparalleled bipartisan support here in Washington. Every independent study that has investigated Title V has concluded that the program's management by the Department of Labor through the eight national contractors and states is cost-effective and free of abuse.

In over 16 years as a national contractor, for example, NCSC is proud of the fact that, while we have continually worked to improve the program, we have also constantly sought ways to reduce Federal costs. Although the law allows administrative costs of up to 15%, currently, our administrative cost rate is less than 6%. This savings in administrative costs has enabled us to employ more than 1,000 additional older workers above our DoL required levels.

The success of Title V, moreover, can be attributed to the original concept that low-income older workers have a vital role to play in meeting local community needs. Our staff monitors job sites on a systematic basis to assure that Senior Aides are employed in meaningful jobs and that they are providing communities with needed services.

Senior Aides are working in such jobs as teachers' aides, in secretarial and clerical positions, as paralegals, in information and referral work, in transportation services, in home health care and in meal distribution services. In some locations, Senior Aides are operating highly successful job placement services for older workers in their communities.

As state and local community service budgets have shrunk in recent years, the only way some needed services have been retained or new ones provided has been through the use of Senior Aides. For example, the State of Michigan saw a dramatic escalation of hunger as a result of the recession and massive layoffs in the automobile industry. Senior Aides in a Michigan project were used to initiate and staff a food distribution program that has delivered an average of five tons of meat, produce and canned goods each week for the last two years. This is in addition to the distribution of USDA commodities.

The Title V program has also helped Senior Aides obtain the experience, confidence and job search skills needed to seek out employment not subsidized by the government. Even with record-high rates of unemployment, particularly among older workers, we have seen an increase in the number of unsubsidized jobs Senior Aides have obtained in recent years.

Mr. Chairman, NCSC believes proposals for structural revisions in the Title V program--including shifting all or part of the program funds to the Department of Health and Human Services--are unnecessary, disruptive and a waste of the taxpayers' dollars. There is no agency of the Federal government that has more expertise in carrying out the objectives of this employment program than the Department of Labor. Nor is there any indication that Title V has not been effectively administered by DoL since the Congress placed the program under its jurisdiction more than a decade ago.

The Department of Labor's administration of this program has been characterized by flexibility. DoL has realized that the various participants in the program may have different approaches to meeting program goals, and thus has given significant discretion in operation to the several sponsors. This arrangement is one of the major strengths of the current structure.

While affording flexibility, DoL has also maintained the oversight necessary for effective program operation. This has been accomplished through constant oral communication and written directives. Labor has taken an active role in ensuring equitable distribution and has been responsive to sponsors' requests for interpretation of the Older Americans Act and the federal regulations. DoL has provided periodic training seminars for Title V sponsors. In addition, it has, from time to time, articulated the need for special emphasis on different areas of program implementation. Within the past several years, sponsors have been directed to address the issues of environmental quality and energy conservation, and they have responded by creating a number of enrollee positions to meet those needs.

Although there has been much talk about problems in coordination throughout our sixteen years operating this program, NCSC has seen relatively few problems with respect to this issue among Title V sponsors. We are in compliance with and will continue to work towards meeting the requirements of Section 503(a) of the Older Americans Act, as amended, which mandates us to consult with state and area agencies on aging, with regard to the location of needed projects and the assessment of community needs to be met by such projects.

The effective application of this provision is evidenced in the area of equitable distribution. In 1983, the Florida State Title V Director indicated that as a result of 1980 census changes, Fort Lauderdale and West Palm Beach were grossly underserved. NCSC responded by significantly increasing the size of both projects. Currently, we are working with Green Thumb on realizing our slots in several areas of Maryland, in an effort to meet the state's equitable distribution formula.

Today, more than ever, older workers need Title V. Long-term unemployment among workers age 55 and over has been near record-breaking levels throughout 1983 and early 1984. While the Title V program represents the only major government response to the needs of older workers, this modest employment program enrolls only 62,500 of an estimated eight to ten million eligible older Americans. Recognizing the vital need for the program and the tremendous contribution these older workers are making in our communities, we should take affirmative action to protect Title V. Although some Federal programs may warrant significant administrative adjustments to bring about improvement, in the case of Title V, we should not tamper with a time-tested and successful system which has consistently proven its worth.

The National Council of Senior Citizens urges the Committee to permit the Title V sponsors to build upon past accomplishments by reauthorizing Title V for a minimum of three years. It should remain a separate categorical program, retaining its current structure at the Department of Labor. Funding levels should be increased to provide additional employment opportunities to the growing population of low-income older persons. Finally, NCSC recommends that the FY 1984 authorization for Title V be increased $2.15 million, from $317.3 million to $319.45. The Title V program is currently operating at the $319.45 million level for the 1983-1984 program year because of the additional funding provided by the Congress in the Emergency Jobs Act (PL 98-8). An increase in the authorization is necessary to avoid actual program reductions beginning July 1, 1984.

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March 27, 1984

The Honorable Charles E. Grassley
Chairman
Subcommittee on Aging
Committee on Labor & Human Resources
United States Senate
135 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Grassley:

This letter is in response to a question raised at the recent hearing of the Subcommittee on Aging of the Committee on Labor and Human Resources. Considerable attention was given to the process of enrollee position allocation, its relation to the achievement of equitable distribution, and the cooperation among program participants. There seemed to be an underlying assumption that the allocation process is a closed--even a concealed process--with little opportunity for scrutiny by interested parties including state agencies on aging. There was also an implication that considerations of equitable distribution play a relatively unimportant role in the allocation process. The contrary is true.

The allocation of enrollee positions among the states is determined by a formula mandated by Congress. National program sponsors cannot affect the number of positions a state receives.

The process of allocating positions within a state involves the participation of a number of parties, including the national sponsors. The state agency on aging is a participant in the process, usually the determining factor. It has been clearly and formally stated since the Act's revision in 1978. The current legislation deals with the subject in Section 502(d)(1) as follows:

> "Whenever a national organization or other program sponsor conducts a project within a State, such organization as program sponsor shall submit to the State agency on aging a description of such project to be conducted in the State, including the location of the project, 30 days prior to undertaking the project, for review and comment according to guidelines the Secretary shall issue to assure

1961 20th ANNIVERSARY 1981
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efficient and effective coordination of programs under this title."

Each state agency is expected to prepare a proposed equitable distribution table or chart--and most do--to guide the sponsors in their assignment of Title V participants. As stipulated in the quoted section of the law, a grant pre-application is then submitted by the sponsor to the state agency on aging showing the geographic distribution of positions within the state. The state agency has thirty days in which to respond. By law, differences are to be resolved by the Assistant Secretary of Labor (ETA). Never have disagreements needed to come to this level, however.

While the state agencies on aging are encouraged to provide input into the process, many do not exercise this right. As of this date, for example, only six state agencies on aging (in the 27 states in which we operate) have submitted any comments in response to our 1985 grant pre-application.

In addition to the state agencies on aging, the newly created "Single Points of Contact" in each state are also given the opportunity to participate in the allocation process. The SPOCs are part of a new intergovernmental review system for federal programs designed to provide state and local governments with increased opportunities to influence federal actions affecting their jurisdictions. Copies of our grant pre-application are submitted to these review agencies for their comments and recommendations. Enclosed are two pages related to this process--generally and as illustrated in the case of Iowa.

The law mandates that major consideration be given to equitable distribution in the allocation of positions within states. It certainly is a major consideration in determining where our positions will be distributed. However, it is not the only consideration. Rigid adherence to formula is often impossible and many times undesirable. In 1979, in response to a request from your office the GAO evaluated the position distribution in Iowa. It concluded that adherence to a strict proportional distribution formula would spread the available positions so thin that their impact in any one area would be negligible and the cost of administering such a widespread program would be prohibitive. "Equitable" means fair and reasonable. It should not be interpreted to mean equal nor even proportional in a strict sense.

Following are a number of examples which should demonstrate our commitment to the goal of achieving an equitable distribution of positions when possible as well as the cooperation and coordination involved.

On the basis of equitable distribution, the State of Alabama determined that Jefferson County was underserved and requested the placement of additional slots in this locale. In response to this request, NCSC in July 1983 added 32 slots to its new project in Jefferson County.

In 1983, the State Title V Director in Florida indicated that as a result of 1980 Census changes, Fort Lauderdale and West Palm Beach were grossly underserved. His equitable distribution plan called for substantial increase in both areas. NCSC responded by nearly doubling the size of its Fort Lauderdale project and significantly increasing the number of slots in West Palm Beach project.

In 1983, NCSC moved the slots in its Owosso, Michigan project to a newly established project in Flint. This action was in response to the state equitable distribution plan which showed the Lansing area overserved (NCSC had projects in both Lansing and Owosso) while the Flint area was underserved.

New York City has historically been underserved according to the state's equitable distribution plan. In an effort to correct existing imbalances, whenever NCSC has had an increase in its allotment of positions for New York State, we have made every effort to place those positions in New York City.

To conclude, the allocation process is not a closed one. There is considerable opportunity for input at different stages in the process. The examples mentioned should demonstrate the importance given to equitable distribution and illustrate the considerable amount of cooperation that exists within the program. I hope the information provided will put to rest any doubts about the openness of the process. We thank you for your endeavors on behalf of older Americans. We at NCSC welcome the opportunity to provide any assistance the Subcommittee might need in its reauthorization efforts.

Sincerely,

William R Hutton

William R. Hutton
Executive Director

Enclosures

OF SENIOR C
PRESIDENT
JACOB CLAYMAN
EXECUTIVE DIRECTOR
WILLIAM R. HUTTON
925 15th Street, N.W.
Washington, D. C. 20005
Telephone: 347-8800, Code 202

SENIOR AIDES

Y DIRECTOR
LOUIS H. RAVIN

A Program Sponsored by the National Council of Senior Citizens for the U.S. Department of Labor

February 14, 1984

Dear Sir/Madam:

In accordance with U.S. Department of Labor Bulletin OW84-5, attached is one copy of the National Council of Senior Citizens Preapplication for Federal Assistance to continue the Senior Community Service Employment Program under Title V of the Older Americans Act.

A copy of this proposal has been mailed to each State Office on Aging and each Single Point of Contact in states where we administer a project.

Should you wish to submit written comments, please do so within the next 30 days. These comments should be submitted to us at the National Council of Senior Citizens. A copy should also be sent to the following address:

Mr. Willis J. Martin
Chief, Division of Older Worker Programs
Employment & Training Administration
U.S. Department of Labor
601 D Street, N.W., Room 6022
Washington, D.C. 20213

In the meantime, we are looking forward to the continuation of a successful working relationship with your agency during the next program year.

Sincerely,

Louis H. Ravin
Deputy Director

Enclosure

GEOGRAPHIC AREAS TO BE SERVICED

NUMBER OF JOB SLOTS

IOWA	POSITION LEVELS	FEDERAL FUNDING
	121	
PROJECT SITES	USDOL FUNDED	
Council Bluffs	60	
Counties of:		
Cass	7	
Crawford	4	
Fremont	3	
Harrison	3	
Mills	3	
Monona	3	
Montgomery	3	
Page	3	
Pottawattamie	26	
Shelby	5	
Sioux City	61	
Woodbury County		

NATIONAL COUNCIL OF SENIOR CITIZENS

National Council of Senior Citizens
925 15th Street, N.W. • Washington, DC 20005 • Phone (Area Code 202) 347-8800

Presidents Emeriti
James Carbray
Whittier CA

Nelson H. Cruikshank
Washington DC

President
Jacob Clayman
Washington DC

Executive Director
William R. Hutton
Washington DC

MAY 10 1984

May 4, 1984

The Honorable Charles E. Grassley
Chairman
Subcommittee on Labor & Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Grassley:

This is in response to your letter dated April 23. Thank you for the opportunity to provide further information for the record. Following are the answers to the two questions appended to the letter:

Question

1. The number of job slots available in this program nationally is 62,500. Do you have figures for how many people actually are enrolled in the program on an annual basis? And do you have figures on the length of time individuals remain in the program?

What I am trying to get at here is whether we are paying for a fairly stable pool of people in this program or whether there is some turnover so that other people have opportunities to participate? Does your organization keep any figures which would help us get a handle on this?

Answer

NCSC has 10,199 positions allocated to it by the Department of Labor and receives funds intended to be adequate for funding this number of enrollees. In fact, we establish 10,898 positions on a 12-month basis. Because of its methods of operation, NCSC is able to increase the number of program participants above the number of slots required by the Department of Labor, and, at the same time, to provide leave, health coverage and unemployment compensation, and worker compensation benefits.

The most recent data available (December 1983) show that 2,510 participants left the program during the six-month period preceding the report.

1961 20th 1981 ANNIVERSARY
A TIME OF CHALLENGE
A TIME FOR COMMITMENT

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island • **Second Vice President,** George J. Kourpias, Washington, D.C. **Third Vice President,** Einar O. Mohn, Menlo Park, California • **Fourth Vice President,** Dorothy Walker, Detroit, Michigan • **Secretary-Treasurer,** J. Al. Rightley, Rochester, Michigan • **General Counsel,** Robert J. Mozer, New York; James J. Kennedy, Jr., Washington, D.C.

Annualized, NCSC's yearly exit rate is 46%. Thus, possibly 5,000 new enrollees can enter in the Senior AIDES Program each year. We estimate that from 13,000 to 15,000 different individuals are employed on the program during a year.

The average stay in the program appears to be 30 months; the length of time spent as a Senior Aide correlates with age at time of entry into the program, those age 55 to 64 staying for shorter periods. Our data suggest that younger entrants stay the shortest time because they find unsubsidized placements.

The duration of stay increases with older entrants and then declines past age 70, when exists are due to poor health.

Question

2. You stated that your organization incurs an administrative cost rate of six percent. Two questions:

First, how many enrollees are used by NCSC to work on administrative or support activities for Title V projects, in the national office and in subcontractor offices? And, can you tell us how much this is worth in administrative overhead costs?

Second, what percentage of your subcontractors pay their own administrative costs? And, if you included all administrative costs (not including enrollee activities) of your national office and the subcontractors as a percentage of total NCSC program outlay, what would be the resulting figure?

Answer

First - In keeping with the regulations of March 25, 1980, Federal Register, NCSC instructs its subcontractors that "Project sponsors shall, to the extent feasible, give enrollees first consideration for work assignments involving the operation of the project" (29 CFR, Part 89.25(d)).

303 Aides (20 hours weekly), the equivalent of 1.1 full-time persons for each of NCSCs 137 projects sites, work on administrative or support activities, at a yearly value of $1,250,000. This figure is derived from a definition of "administration and support" which includes Aides who administer job development programs under the aegis of the project director. These efforts help both Aides and non-Aides to find unsubsidized jobs, opening up slots in the Title V Program and enabling individuals who may be ineligible, fur the program, to find employment elsewhere.

Second - All local project sponsors provide the non-federal match in cash or kind required by law (Section 502(c) of the Older Americans Act). NCSC requires that, as part of this match, the local subsponsor pay the salary and expenses of the project director whom they hire (subject to approval and technical supervision by NCSC staff). This arrangement assures that the sponsoring nonprofit agency with whom we contract is community-based and community-supported, and is operating day-to-day consistently with federal policies and performance standards.

On the average, and in the great preponderance of instances, one-half of the statutory 10% match includes the cost of the Project Director. On that basis, assuming 5% for the local administrative costs and 6% for NCSC administration, the total for national and local project costs would be 11% of the federal grant--but note that the local contribution is a non-federal match. Total administrative costs would be about 9% of the total of the federal grant plus local match. If the essential question is how much of the Federal dollars get to the intended beneficiaries, then the answer is at least 90¢ out of each Federal dollar goes to Senior Aides in wages and fringe benefits, and direct supportive benefits.

In your letter, you also ask how well the enrollees fare in the job market after they leave the Title V Program. We do not conduct any extensive follow-up, but if you have a continuing interest, we would be glad to undertake a study.

With respect to information on the distribution of slots within the states, we have already responded at length in our letter to you on the subject dated March 27, 1984, a copy of which is attached for your convenience.

Sincerely,

William R. Hutton

William R. Hutton
Executive Director

Attachment

Senator **Grassley**. First of all, I want to thank all of the contractors, including the others who will be testifying. We appreciate very much the 13-percent increase in employment this year. We feel that that is very much a good use of funds, a very good trend for the future, particularly as the percentage of the population of America becoming senior citizens increases from year to year. We are glad for that.

Although I have questions on several different subjects, I am only going to ask one orally and then the rest I am going to submit for written response. We are particularly interested in knowing whether you track individuals who make the transition to private sector jobs and whether you have any analysis of what kind of jobs they get and how long they stay in those jobs.

I know that you probably are not prepared to answer that today, and so I would encourage you to submit those in writing unless you can speak to that today. But even if you can, I think I would like to have the formalized response and the studied response that you can better give in writing, so I hope you will do that.

I also, along that line, would like to know the extent to which you do track. Is there some of that going on now, Ruth?

Ms. **Kobell**. As you know, Senator, I am not immediately involved in the administration of the programs, and would be anxious to provide you as much detail as you wish.

One of the challenges of this program is that at the same time we are making every effort to cut administrative costs we are anxious to maintain the quality of administration which certainly involves working to find for those individuals whom we place quality employment which will both enhance their lives and their earning capacities.

We do, I think, on an informal basis try to track their employment records. We have in several instances done a careful, rather long-term tracking to judge the length of time that they have stayed employed. We have had a pattern where, in those instances where an employment opportunity did not seem to work out we have been able to provide an opportunity for those people to come back on the program so that there was a chance to again put them to work and help them develop skills.

Because most of these workers have been out of the labor market, they themselves need some reinforcement of not only training, but of self confidence.

As an old farmer out in South Dakota said to us a number of years ago: "How do I write a résumé? How do I talk about in terms of previous employers? I have never worked for anybody else. I have farmed all my life and now I have lost my farm."

So, these are some of the challenges, but we do have some information and we will be delighted to present it to you for the record. I know that in Oregon, particularly, there was a careful study of the longevity of placement, and I think in Kansas. I can certainly identify other States for you and I am glad you raised the question.

Senator **Grassley**. Mr. Reilly.

Mr. **Reilly**. We have been doing some work along this line and we will answer that for the record.

Senator **Grassley**. OK. Mr. Anderson.

Mr. **Anderson**. Yes, Senator Grassley, we have been doing some things along these lines. By virtue of the fact that our program is pretty much rural, it is not very difficult for u[illegible] track. However, we will provide you with detailed information for the record.

[Information supplied for the record follows:]

The Forest Service tracks enrollees who have been placed in unsubsidized employment during their first year of employment and requires its projects to conduct follow-up activities at least twice during the first three months after placement. Our efforts focus upon the first year of private sector employment and generally our projects do not conduct follow-up beyond the first year. We do not maintain detailed records which examine the longevity of our placement and we have not conducted studies to assess the success of our placement efforts.

Senator **Grassley**. Mr. Hutton.

Mr. **Hutton**. I am sure you agree, Senator, that this is the kind of research which every organization really should do, but funds have not been provided to national contractors for that kind of research.

What we have done is encouraged the local project directors, who are in constant touch in their communities with these people, to provide this work. We will respond with the kind of material they have given us over the past years.

Senator **Grassley**. A couple of other unrelated questions, and let me suggest that it would save me repeating the questions if the next panel would not only respond when they get here to what I just asked, but also answer, as contractors, how you would react to the organization of the National Association of State Units on Aging, which has proposed that title V operations be included in the State plans submitted by the Governor.

Would your organization have a problem with that proposal?

Ms. **Kobell**. I must say I have not studied it in detail. We have worked closely with State and area agencies, certainly, in the equitable distribution of employment opportunities as well as in supporting programs that the aging network has become involved in.

Over 2,000 of our workers, for instance, work in nutrition sites which help to expand the effectiveness of that very important work. We believe that one of the successess of this program has been that there has been considerable flexibility.

We can get to the place where you spend all your time figuring out what the regulations say and filling out reports, and I would want to review that in some detail.

Senator **Grassley**. OK.

Mr. **Reilly**. My reaction is that the title III funds, which are the main focus of State plans and the hearings on them, are essentially unearmarked. The purpose of these plans and hearings is for local feedback on how these funds should be distributed or redistributed, from one kind of service to another. In this case, what you have is a completely earmarked set of funds for a very specific purpose. In that context, I don't believe that the nature of the title V program really fits the State plan and public hearing process. NCOA already consults with the State units on the placement of new projects and the placement of new slots. Therefore, this does not seem to be a useful change in the current process.

Senator **Grassley**. Mr. Anderson.

Mr. **Anderson**. As far as the Forest Service is concerned, Senator, we work very closely with the agencies on aging as far as the equitable distribution plan is concerned. Anything beyond that, I am not familiar with at this point in time. I will attempt to investigate that and give you something in more detail.

[Information supplied for the record follows:]

The Forest Service has actively participated in meetings with national and State SCSEP sponsors to achieve an equitable distribution of SCSEP employment positions. We are committed to the principle of equitable distribution and we believe that this has been demonstrated in our negotiations with other sponsors. We believe that current equitable distribution state plans, and coordination efforts are adequate.

Senator **Grassley**. OK.

Mr. **Hutton**. We would like to know more about what that plan is. We do at the moment actually administer some State plans on behalf of the States.

Senator **Grassley**. Let me apologize for assuming that you knew about the proposal. We can submit that in writing as well.

My last question to both this panel and the next panel refers to that dialog with the General Accounting Office on how they reported that the Department of Labor made an allocation of the slots and left it pretty much up to organizations like yours.

So I would ask whether or not you can tell us how you decide what distribution of slots you would propose to the Department, and whether or not your deliberations on this question are public and do you keep a record of the deliberations.

Ms. **Kobell**. Well, again, Senator, I have not recently been involved in that. I did, as you know, serve a brief period when I was acting administrator of Green Thumb and can hark back to that.

I think we all need to understand that the allocation of title V funds is done on a formula basis, written into the law, that in part targets funds to States on the basis of population. You will remember there was some shifting around when we got new census data a couple of years ago.

It is also allocated in terms of need within the State. As the General Accounting Office pointed out, the national organizations which now administer the program have done so on a rough percentage basis for some years. As you know, Green Thumb is the largest and oldest and serves, along with the Forest Service, primarily rural areas, so that there is a special target of serving rural workers.

I think that the national contractors on an informal basis propose a formula to the Department of Labor because they are aware of resources and of gaps in service. Sometimes when you have a small increase in the number of jobs you continue the amount of available resources, projects pretty much stay where they are.

I think there has been no effort to be secret about this. Rather, it has been that those people who are working are quite often best able to most effectively target additional resources.

As I say, we recognize that we serve less than 1 percent of the people who are eligible for this program and therefore there is a constant challenge of deciding where we can best target additional resources for cost-effective administration because if you are scattered all over the country, it becomes very expensive administratively.

Senator **Grassley**. Mr. Reilly.

Mr. **Reilly**. The question of additional slots came up particularly in relation to the emergency jobs bill when there was a substantial number of slots added to the program.

The way we went at it was to look at the equitable distribution plans that had been developed in each State, and looked at where our slots were.

We then consulted with the State units on aging and the other national contractors.

In every instance when NCOA is to establish a new project within a State, we confer with the State unit on aging and seek their recommendation for its location. We have always accepted the State units recommendation.

In every instance when additional slots become available within a State, we confer with the State unit on aging and the other national sponsors to reach agreement on locations which contribute to improvement of the equitable distribution of slots. We have always reached a mutual agreement with the State unit on the location of new slots.

The meetings vary in formality from State to State. Some States produce minutes and some do not. Meetings between the national contractors are informal.

Mr. **Anderson**. I think that what has been stated is about the way we all do it. We consider the equitable distribution and the areas that are underserved that need serving, and we go about making allocations that way, usually. So I cannot add any additional thing to what has already been said.

Mr. **Hutton**. Senator Grassley, about the only thing I can add to that is we are all part of this system of open evaluation and discussion both among ourselves—the national contractors and States—and with the Department of Labor.

The local sponsors that we have make annual assessments of community needs. The Department of Labor knows where the heavy incidence of unemployment is, and together with the formal list as adopted, we try to fit those together so that the community gets the best value and the goals are reached.

Senator **Grassley**. Well, in summation, would it be fair for me to conclude that the meetings obviously are very informal; that the deliberations on the questions are not public, with no intent to keep them nonpublic or private, and you do not keep a record of the deliberations because they are very informal?

Ms. **Kobell**. That is right.

Mr. **Reilly**. That situation varies from State to State.

Senator **Grassley**. OK.

Ms. **Kobell**. I would think that it also needs to be reiterated that any recommendations and proposals to the Department are simply that. Certainly, the Department carries the responsibility for allocation and, as was pointed out, has on occasion made some different decisions. But this is simply an advisory contribution, as it were.

Senator **Grassley**. Mr. Hutton.

Mr. HUTTON. Yes. I just wanted to add one thing. It is on paper; it is written on paper, it is produced on paper, it goes to the Department on paper. We, under the law, have to contact the States, and do, and work with the States.

Senator GRASSLEY. Well, that is the end of my questioning except for what we leave either to submit to you again or what I have asked you to submit in writing or what you have told me you would submit in writing. We would appreciate that if that could be done in 15 days. Thank you all very much.

We have three members of the next panel. David Affeldt represents the American Association of Retired Persons, and also the National Association of Hispanic Elderly. Samuel Simmons is president of the National Caucus and Center on Black Aged. Dr. Douglas Glasgow is vice president in charge of Washington operations of the National Urban League.

If I could ask you if you would go through your testimony as you would normally do, and then I would go back and ask each of you to comment on the three points that I brought up to the previous panel so that we kind of have the questioning together and your testimony simultaneously.

Go ahead, David.

STATEMENT OF DAVID AFFELDT, REPRESENTING THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND THE NATIONAL ASSOCIATION FOR HISPANIC ELDERLY; SAMUEL J. SIMMONS, PRESIDENT, NATIONAL CAUCUS & CENTER ON BLACK AGED, INC.; AND DOUGLAS G. GLASGOW, VICE PRESIDENT, WASHINGTON OPERATIONS, NATIONAL URBAN LEAGUE, INC.

Mr. AFFELDT. Thank you very much, Senator Grassley. I hope you will not get bored hearing from me so often.

Senator GRASSLEY. No.

Mr. AFFELDT. I will be brief.

Senator GRASSLEY. I do want to thank you for your patience, too, in answering so many of our requests that you and your organization testify.

Mr. AFFELDT. Thank you.

AARP has four key principles for title V during the reauthorization of the Older Americans Act. First, we recommend that the Senior Community Service Employment Program should remain in the Department of Labor as a separate program. AARP believes that the Department of Labor should administer title V because it has primary responsibility for employment and training activities.

Congress gave careful consideration to the proper placement of the national senior corps when it created the Senior Community Service Employment Program. This decision was made after much deliberation. The reasons are equally compelling today as they were more than a decade ago when Congress gave overwhelming approval for the Senior Community Service Employment Program.

Finally, those who favor shifting title V from the Department of Labor must produce evidence on two key points. First, they must show that the program will operate more effectively and efficiently at another agency without causing great disruption. Second, they must show how this will occur. This case simply has not been made. For these reasons, we reaffirm that the Department of Labor should continue to administer title V.

Second, the Senior Community Service Employment Program and the Older Americans Act should be extended for at least 3 years. Title V has been successful and deserves to be continued for that period of time. This 3-year extension will also provide greater continuity for the Senior Community Service Employment Program, as well as prevent disruptive starts and stops.

Third, authorization levels should be adjusted to take into account higher costs and to permit some expansion to enable more low-income older persons to participate. The Senior Community Service Employment Program costs have increased in recent years because of steadily rising worker compensation costs, Federal unemployment taxes and Social Security taxes. In the case of Social Security, this will be more evident in the years ahead.

Fourth, AARP recommends that the fiscal year 1984 authorization for the Senior Community Service Employment Program be boosted by $2,150,000, from $317.3 million to $319.45 million.

Title V is currently funded at $319.45 million for the 1983-84 program year, and this amount is actually above the authorization for fiscal year 1983 by $22,950,000 because the Congress, in effect, provided a waiver for title V when it approved additional funding under the emergency jobs law, Public Law 98-8.

Title V is funded at $317.3 million for fiscal year 1984, which is the full amount of the authorization. Fiscal year 1984 will cover the period July 1, 1984, through June 30, 1985, since the Senior Community Service Employment Program is forward-funded by 9 months.

An increase in the authorization is necessary to avoid reducing the number of average hours for title V enrollees or to cut back on the number of temporary workers in the program. We consider either alternative to be unacceptable. We urge the committee to work for this small increase which can do so much for low-income older Americans who now participate in title V and want to in the future.

In conclusion, the Senior Community Service Employment Program has demonstrated its value and worth over the years. It deserves to be continued in the Department of Labor and with increased authorization levels.

We believe that our title V proposals are reasonable, realistic and needed. We look forward to working with the subcommittee to improve the Senior Community Service Employment Program.

Thank you very much, Senator Grassley.

[The prepared statement of the American Association of Retired Persons and responses of Mr. Affeldt to questions submitted by Senator Grassley follow:]

STATEMENT BY

AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

SUBCOMMITTEE ON AGING
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

MARCH 13, 1984

35-522 O—84——55

Senator Grassley and Members of the Subcommittee on Aging, the American Association of Retired Persons is pleased to testify at this hearing on the Title V Senior Community Service Employment Program (SCSEP). The Association supports four key principles for Title V during the reauthorization of the Older Americans Act.

A. Retain Title V in the Department of Labor

First, the SCSEP should remain in the Department of Labor as a separate program. AARP believes that the Department of Labor should administer Title V because it has primary responsibility for employment and training activities. Congress gave careful consideration to the proper placement of the national senior corps when it created the SCSEP. This decision was made after much deliberation. The reasons are equally compelling today as they were more than a decade ago when Congress gave overwhelming approval for the SCSEP.

Finally, those who favor shifting Title V from the Department of Labor must produce evidence on two key points. First, they must show that the program will operate more effectively and efficiently at another agency without causing great disruption. Second, they must show how this will occur. This case has simply not been made. For these reasons we reaffirm that the Department of Labor should continue to administer Title V.

B. Three-Year Reauthorization

Second, the SCSEP and other Older Americans Act programs should be extended for at least three years. A program as successful and effective as Title V deserves to be continued for at least three years. This will provide greater continuity for the SCSEP as well as prevent disruptive starts and stops.

Congress has traditionally approved three-year extensions for Title V. This helps program administrators in planning their activities by providing them with sufficient lead time. At the same time, a three-year extension enables the Congress to review the program periodically.

C. Increased Authorization Levels

Third, authorization levels should be adjusted to take into account higher costs and to permit some expansion to enable more low-income older persons to participate. The SCSEP costs have increased in recent years because of steadily rising worker compensation costs, federal unemployment taxes, and Social Security taxes.

D. Increased Authorization for FY 1984

Fourth, AARP recommends that the FY 1984 authorizations for the SCSEP be boosted by $2.15 million, from $317.3 million to $319.45. Title V is currently funded at $319.45 million for the 1983-84 program year. This amount is actually above the SCSEP authorization for FY 1983 by $22.95 million because the Congress provided, in effect, a waiver for Title V when it approved additional funding in the Emergency Jobs law.

Title V is funded at $317.3 million for FY 1984 which is the full amount of the authorization. FY 1984 will cover the period July 1, 1984 to June 30, 1985, since the SCSEP is forward funded by nine months.

An increase in the authorization is necessary to avoid reducing the number of average hours for Title V enrollees or cutting back on the number of temporary workers in the program. AARP considers either alternative to be unacceptable. We urge the Committee to work for this small increase which can do so much for low-income older Americans who now participate in Title V or want to in the future.

E. Conclusion

In conclusion, the SCSEP has demonstrated its value and worth over the years. It deserves to be continued in the Department of Labor and with increased authorization levels.

We believe that our Title V proposals are reasonable, realistic, and needed. We look forward to working with the Subcommittee to improve the SCSEP.

1984 MAY 18 PM 2:56

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

26 YEARS OF SERVICE

May 16, 1984

MAY 21 1984

TO: Senator Grassley

FROM: David A. Affeldt DA

RE: Response to questions in April 23, 1984 letter concerning the Title V Senior Community Service Employment Program

1. I believe that AARP has the best record of finding private sector employment of any of the national sponsors.

Q. Is AARP able to do this and at the same time to give priority to people over 60 in their program?

A. Overall, the average age is 67 for an AARP enrollee. For the March 1984 Quarterly Progress Report--the most recent report for AARP--52.4 percent of all placements were 60 or older. AARP placed 870 enrollees in unsubsidized employment, and 456 were 60 years or older. Enclosed is a table showing the placement by age.

Q. To what do you attribute AARP's success in finding private sector employment for enrollees? Is it attributable to some transferable methodology, that is transferable to other sponsors and the states, or does it have more to do with the population AARP deals with?

A. AARP has had a long-term philosophy that Title V is a work experience program to help people find jobs in the private sector. As a consequence, a large part of AARP's administrative costs is devoted to job development. This has contributed to AARP's exceptionally high unsubsidized placement rate--currently about 40 percent on an annualized basis. The net impact is that AARP has developed a sophisticated job development program which has yielded impressive dividends in unsubsidized placements.

Vita R. Ostrander
AARP President

Cyril F. Brickfield
Executive Director

National Headquarters 1909 K Street N.W. Washington D.C. 20049 (202) 872-4700

2Q. I would like at ask you the same question I asked the preceeding panel: namely, whether you make any effort to track enrollees who move into private employment?

If you do, can you summarize for us what your conclusions are?

A. AARP tracks enrollees for 90 days as required by the regulations. Our Senior Community Service Employment Program (SCSEP) would like to track beyond this period. However, we do not because present administrative funds will not allow it.

3Q. Can you tell us what the average annual income of your Title V enrollees was in fiscal year 1983?

A. Information is not available concerning the average annual income for AARP's Title V enrollees. If there was sufficient funds to computerize the data, AARP could provide this information. However, we can inform you that almost all (about 98 percent) of AARP's Title V enrollees have incomes at or below the poverty line, and only 2 percent have incomes between 100 percent and 125 percent of the poverty threshold.

March 1984 QPR

Current Enrollment	Placements by Age	
55-59 - 2,790	55 - 69	
	56 - 73	
	57 - 103	
	58 - 97	
	59 - 72	= 414
60-64 - 2,819	60 - 87	
	61 - 71	
	62 - 55	
	63 - 53	
	64 - 39	= 305
65-69 - 1,597	65 - 26	
	66 - 24	
	67 - 19	
	68 - 14	
	69 - 16	= 99
70-74 - 954	70 - 14	
	71 - 9	
	72 - 11	
	73 - 7	
	74 - 4	= 45
75 and over - 548	75 - 2	
	78 - 1	
	79 - 1	
	80 - 2	
	87 - 1	= 7

ANPPM

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May 25, 1984

Honorable Charles Grassley
Chairman
Subcommittee on Aging
Senate Committee on Labor and Human Resources
Room 428
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Grassley:

This is in response to your follow-up questions in connection with the hearing on the Title V Senior Community Service Employment Program.

Question 1:	I would like to ask you the same question I asked the preceding panel: namely, whether you make any effort to track enrollees who move into private employment? If you do, can you summarize for us what your conclusions are?
Answer 1:	The Asociacion follows the regulations in tracking Title V enrollees for 90 days after they move into unsubsidized employment. We do not track beyond this period because of the costs involved. We believe that this money is more effectively used by focusing on job development activities and other procedures to enable more of the Asociacion's enrollees to become placed in the private sector.
Question 2:	Can you tell us what the average annual income of your Title V enrollees was in fiscal year 1983?
Answer 2:	Present funds do not allow the Asociacion to computerize data concerning the average

REGIONAL CENTERS Los Angeles CA Miami FL Washington DC New York NY

National Association For Hispanic Elderly
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annual income of Title V enrollees. Practically all of our enrollees have incomes below the poverty thresholds, and every enrollee has income below the 125-percent poverty income standard as required by law. Enrollees who misrepresent their income to qualify when they would not be able to participate are removed from the rolls. Several of the participants in the Asociacion's program have no or practically no income.

Sincerely,

David A. Affeldt

David A. Affeldt
Consultant

BEST COPY AVAILABLE

Senator **Grassley**. Thank you.

Go ahead, Mr. Simmons.

Mr. **Simmons**. The National Caucus and Center on Black Aged appreciates this opportunity to testify at the Subcommittee on Aging's hearing on the reauthorization of the title V Senior Community Service Employment Program. We have a more comprehensive statement that we would like to leave for the record.

The SCSEP has been an extraordinarily effective program since its creation in 1973. It has not only served our Nation well, but also older minorities. For the period ending June 30, 1983, older minorities constituted about 33 percent of all of the title V enrollees, and of that number blacks constitute approximately 21 percent. NCBA's current enrollment is approximately 1,534 at the present time, but we have 1,750 people currently employed.

Title V has been an exceptionally administered program from any standard that you look at. NCBA believes that this program should remain in the Department of Labor rather than being transferred to HHS. Title V is an employment program and is therefore more appropriately administered by the Department of Labor.

Units within HHS simply do not have the kind of experience and expertise to administer an employment program even though they do a very effective job in terms of administering the programs that they have at the present time. We would also be opposed to a partial transfer of the program, as has been advocated by some in the past.

We also would be concerned about the proposal whereby title V funds would be allocated on a two-factor formula; in other words, on per capita and population, whereby the funds would be allocated on the basis of 60 and over rather than being allocated on a two-phase formula as it is now done under the present title V.

We also feel that there should be increased authorization for the program. We urge the subcommittee to approve an increased authorization for title V because payroll tax and worker compensation insurance costs have jumped in recent years. In all probability, these costs will continue to increase in the future. Social Security payroll taxes, for instance, will rise steadily because of the enactment of the 1983 Social Security Act amendments. This will simply be a fixed cost which title V projects must absorb.

NCBA also favors expansion because this program is reaching only a small proportion of persons who are potentially eligible to participate in title V. Despite an overall improvement in the employment picture, older workers have not benefited to the same extent as younger persons.

For example, the percentage rate of reduction in unemployment was about 2.3 times as great for individuals under 55 during 1983 compared to those 55 or older. Unemployment dropped by 21 percent for workers under 55 from January to December 1983, in contrast to only 9.3 percent for older Americans.

Another barometer is the civilian labor force, which increased by 1.261 million for persons aged 16 to 54 from 1982 to 1983. However, the civilian labor force remained essentially static for persons 55 or older, increasing by only 2,000 during this 12-month period.

The bottom line is that older workers are still in a recession. Title V can be an effective vehicle to enable low-income Americans to become gainfully employed while helping others at the same time by rendering valuable community service.

Finally, NCBA urges the subcommittee to retain the existing language which calls upon title V projects to serve eligible minority individuals in proportion to their numbers in the State. This provision, plus the Department of Labor decision to fund national minority aging organizations, has helped to assure that this program is fully responsive to the unique needs of older minorities. NCBA knows of no other program that has served older minorities as effectively as this has.

In conclusion, your committee, Senator, has had a longstanding record of support for title V. Hearings held by this subcommittee has helped pave the way for legislation to convert the older worker mainstream projects into a permanent, ongoing senior employment program.

Your subcommittee has carefully monitored title V over the years. The program has matured and has always received strong bipartisan support. We believe our proposals will help to improve title V during the mid and late 1980's. We urge the subcommittee to adopt these recommendations during the markup session on the Older Americans Act reauthorization bill and we look forward to supplying you with any kind of additional information we can, and look forward to the challenge and opportunity to make this program more meaningful and more relevant to the needs of the elderly in this country.

Thank you very much.

[The prepared statements of the National Caucus and Center on Black Age, Inc., and responses of Mr. Simmons to questions submitted by Senator Grassley follow:]

TESTIMONY BY

THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

March 13, 1984

The National Caucus and Center on Black appreciates the opportunity to testify at the Subcommittee on Aging's hearing on the reauthorization of the Title V Senior Community Service Employment Program (SCSEP). We have a comprehensive statement, which covers other provisions in the Older Americans Act as well as Title V. We ask that this lengthier statement also be included in the hearing record.

The SCSEP has been an extraordinarily effective program since its creation in 1973. It has not only served our nation well but also older minorities. For the period ending June 30, 1993, older minorities constituted about 33 percent of Title V enrollees. Blacks represented 21 percent of the total enrollment. NCBA's SCSEP has 1,534 authorized positions, but about 1,750 persons are currently enrolled.

Retain Title V in the Department of Labor

Title V has been an exceptional program by any standard one would choose to use. It has been effectively administered. Administrative costs are low.

NCBA believes that the SCSEP should remain in the Department of Labor, rather than be transferred to the Department of Health and Human Services (HHS). Title V is an employment program and is, therefore, more appropriately administered by the Department of Labor. Units within HHS simply do not have the experience or expertise to administer an employment program.

A partial transfer of the SCSEP TO HHS, as recommended in the Administration's fiscal year 1984 budget, could be harmful for older Blacks. First the proposal would change the funding formula which would probably be detrimental for elderly Blacks and other older Americans. Title V funds are now allocated on the basis of a two-factor formula: (1) per capita income and (2) population 55 or older. However, another formula would apply if HHS administered Title V. This would be based on population 60 or older. We question the wisdom of applying a 60-plus formula to a program serving low-income persons 55 or older. Older Blacks would probably be victimized under this formula since they tend to be concentrated more in states with lower per capita income, especially in the rural South. Many of these states would be losers under a switchover to a 60-plus formula.

Increased Authorizations

NCBA further urges the Subcommittee to approve increased authorizations for Title V because payroll tax and worker compensation insurance costs have jumped in recent years. In all probability, these costs will continue to increase in the future. Social Security payroll taxes, for instance, will rise steadily because of the enactment of the 1983 Social Security Act Amendments. This will simply be a fixed cost which Title V projects must absorb.

NCBA also favors expansion because the SCSEP is reaching only a small proportion of persons who are potentially eligible to participate in Title V. Despite an overall improvement in the unemployment picture, older workers have not benefitted to the same extent as younger persons. For example, the percentage rate of reduction in unemployment was about 2.3 times as great for individuals under 55 during 1983, compared to those 55 or older. Unemployment dropped by 21.0 percent for workers under 55, from January to December in 1983, in contrast to only 9.3 percent for older Americans.

Another barometer is the civilian labor force, which increased by 1,261,000 for persons aged 16 to 54 from December 1982 to December 1983. However, the civilian labor force remained essentially static for persons 55 or older, increasing by only 2,000 during this 12-month period.

The bottom line is that older workers are still in a recession. Title V can be an effective vehicle to enable low-income older Americans to become gainfully employed while helping others at the same time by rendering valuable services in their communities.

Retain Minority Language

Finally, NCBA urges the Subcommittee to retain the existing language which calls upon Title V projects to serve eligible minority individuals in proportion to their numbers in the state. This provision plus the Department of Labor decision to fund national minority aging organizations have helped to assure that SCSEP is responsive to the needs of older minorities. NCBA knows of no other program that has served older minorities more effectively, efficiently, and equitably than the SCSEP.

Conclusion

The Subcommittee on Aging has had a long-standing record of support for Title V. Hearings held by the Subcommittee on Aging helped to pave the way for legislation to convert the older worker Mainstream pilot projects into a permanent ongoing SCSEP.

The Subcommittee has carefully monitored Title V over the years. The program has matured and has always received strong bipartisan support. We believe our proposals will help to improve Title V during the mid and late 1980's. We urge the Subcommittee to adopt these recommendations during the mark-up session on the Older Americans Act reauthorization bill.

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STATEMENT
ON
1984 REAUTHORIZATION
OF THE OLDER AMERICANS ACT

PREPARED BY

THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.
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JANUARY 24, 1984

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RECOMMENDATIONS OF THE NATIONAL CAUCUS AND CENTER ON BLACK AGED FOR IMPROVING THE OLDER AMERICANS ACT

INTRODUCTION

The Older Americans Act will soon expire. Congressional hearings have already begun and further hearings are scheduled in the near future to discuss language for the reauthorization of the act. NCBA takes the occasion of the hearings on reauthorization to present its recommendations for improving this important legislation.

NCBA's analysis and recommendations are based on a decade of service to older blacks and of working with the aging network at the national, state, and local levels. NCBA's board of directors includes several nationally renown leaders in the field of aging. In addition, the staff of NCBA has many years of experience serving the elderly and working in the aging network. The following recommendations have been debated at length and represent NCBA's position.

NCBA's mission is to improve the quality of life for older blacks. Most of the following comments are made with this goal in mind. By fine tuning the Older Americans Act to serve minorities better, according to need, we believe that we address current concerns for greater efficiency in the use of scarce resources.

I. SERVING MINORITIES MORE EQUITABLY UNDER THE OLDER AMERICANS ACT

NCBA considers equitable treatment for minorities to be the single most important issue for reauthorization of the Older Americans Act. The recent report of the Civil Rights Commission plus earlier equity studies for the Administration on Aging (AoA) make it clear that aged minorities are not served on the basis of their need for services. Several actions are needed to enable the Older Americans Act to become more responsive to minorities, including legislative, administrative, and regulatory changes.

A. Strong Statutory Language to Serve Older Minorities

First, stronger and more precise statutory language is essential to assure that older minorities are more equitably served. The present standard--based on "greatest economic or social needs"--for targeting services must be replaced. As a practical matter, this test is simply too easy to circumvent. Moreover, the language does not answer to what extent, for example, older minorities, "at risk" individuals or others with "economic or social needs" should be served. In short, the language raises more questions than it answers.

NCBA strongly opposes the status quo because the present requirement has simply not worked. This has been conclusively demonstrated by the 1982 Civil Rights Commission report and other equity studies.

NCBA believes that the Older Americans Act should state affirmatively that older minorities are a priority group for receiving services under Title III. Strong language has helped to make the Title V Senior Community Service Employment Program (SCSEP) responsive to the needs of older minorities, and it can achieve the same result for Title III services. Currently, the participation rate for aged minorities is almost twice as great for Title V as it is for Title III. In fiscal year 1982, the minority aged received about 18 percent of supportive and nutrition services under Title III. On the other hand, older minorities accounted for approximately 33 percent of all SCSEP enrollees.

NCBA further urges that the minority elderly should be served on the basis of their social or physical need for services. We oppose targeting services according to proportionality or some other criterion.

Equity studies typically show that the minority elderly's need for services is about 2 to 3 1/2 times as great as the non-minority aged. NCBA favors targeting based on the following formula. Minorities constitute 13.3 percent of the 60-plus population. Aged Blacks and older Hispanics are about 2.8 times as likely to be poor as elderly Whites (figures are not available for older Native Americans or Pacific/Asians). If you multiply the aged minority's proportion of the 60-plus population (13.3 percent) by the elderly minority's relative poverty factor compared to older Whites (2.8 times as great) this would equal 37.2 percent. This is a rough approximation of the minority aged's relative need for services.

Some interim goals may be established because it may not be possible to reach this objective immediately. Perhaps 25 percent should be an interim objective. The ultimage goal, however, should be about one-third minority participation because the minority aged's need for services is substantially greater than for the non-minority elderly. NCBA believes that strong statutory language, coupled with effective community involvement for targeting, delivering, and monitoring services to the minority aged, can help to resolve many of the problems highlighted by the Civil Rights Commission.

B. Promote Employment and Contract/Grant Opportunities for Minorities

The Civil Rights Commission report also found that minorities have been excluded, to a large degree, from employment opportunities in the field of aging, especially in managerial, administrative, and other executive positions. Similarly, minority business enterprises and service providers have been overlooked by federal, state and local offices on aging. Minority enterprises receive only a relatively small percentage of contracts and grants awarded by offices on aging.

NCBA recommends that affirmative steps should be taken to promote employment, and opportunities for contracts and grants for minorities in the field of aging. We favor strong statutory language to state clearly that federal, state, and local offices on aging should establish appropriate target goals and time tables for increasing on-the-job training, employment, contract and grant opportunities for minorities.

The Administration on Aging should develop suitable regulations, guidelines and program instructions to implement this provision. Additionally, comprehensive current information should be collected concerning the number and percentage of (1) positions held by minorities at state and local offices on aging and AoA, (2) service contracts and grants awarded minority enterprises under the Older Americans Act, and (3) minorities receiving services under the Older Americans Act. Moreover, staff sensitivity skills should be developed concerning the unique problems, values and traditions of the minority aged. These efforts can produce greater awareness of the problems and challenges confronting older minorities, as well as lead to suitable programs to respond to their needs.

C. Definition of Minority

A definition of "minority" should be incorporated into the Older Americans Act. NCBA recommends that the following racial and ethnic groups be included in the definition: Blacks, Hispanics, Asian and Pacific Islanders, Native Americans, Aleuts, and Eskimos.

This language is necessary to provide clear direction for targeting services. NCBA believes that it is fitting and appropriate to have a definition of "minority" because this term will be used throughout the Older Americans Act.

D. Federal Council on Aging

Minority representation should be guaranteed on the Federal Council on the Aging to provide greater assurances that the needs of older minorities are appropriately considered. Currently, the language states that the Federal Council should be representative of rural and urban older Americans, national organizations with an interest in aging, business, labor and the general public. At least five of the members must be older individuals.

NCBA recommends that at least three Federal Council on Aging appointees should be members of minority groups.

II. ADMINISTRATIVE MEASURES

The Older Americans Act has enjoyed strong bipartisan support throughout its history. One important reason is that the programs have been effectively administered without fraud and abuse. NCBA recommends the following changes to strengthen the Older Americans Act.

A. Increased Authorization Levels

One of the first orders of business is to boost the authorization levels to take account of projected inflation and the need to serve a growing elderly population. Overall, funding for AoA-administered programs has remained essentially static since fiscal year 1981, with the exception of Title IV which has suffered sizeable cuts (this will be covered in more detail later in this statement).

NCBA urges that authorized funding for all Older Americans Act programs be increased significantly above present funding levels to meet more adequately current as well as future needs.

B. Assistant Secretary on Aging

Second, NCBA recommends that an Assistant Secretary on Aging should be established to advocate on behalf of the elderly and to administer the Older Americans Act. Congress clearly intended that AoA should be a forceful and effective advocate for the aged when it enacted the Older Americans Act. The legislative history reveals that AoA was to be coequal in status with the Social Security Administration.

AoA, however, has not been able to fulfill that role because it is a subunit in the Office of Human Development Services along with several other agencies. AoA is supposed to coordinate federal programs and activities impacting on older Americans. But AoA has experienced difficulty in carrying out this responsibility, especially when working with higher ranking agencies in other departments.

An Assistant Secretary on Aging would help to provide the visibility and clout that is needed for a federal focal point for the elderly. This issue has been debated for several years. It is an idea whose time has come.

C. Definition of Aging Network

Third, NCBA urges that a definition of "the aging network" be incorporated into the Older Americans Act. We would favor a broad definition to include AoA, state and area agencies on aging, organizations representing older Americans or others with an interest in the field of aging, such as colleges and universities, legal services programs, nutrition providers, and other service providers assisting the elderly.

These groups are keenly interested in improving the lives of older Americans. They implement this objective in many ways--through research, conducting training programs, administering programs to benefit the elderly, advocating on behalf of older Americans, providing legal representation. These organizations are a part of the "aging network" and deserve to be included within the definition.

III. TITLE III SERVICES PROGRAMS

NCBA has developed recommendations to serve minorities more equitably under Title III. Several other actions, however, are needed to strengthen this title which is oftentimes called the heart of the Older Americans Act.

A. Separate Supportive Services and Nutrition Programs

NCBA favors the retention of the separate authorizations under Title III for supportive services and senior centers, congregate meals, and home-delivered meals. We do not support a consolidation of Title III because there is already ample flexibility. Currently, 20 percent of the funding can be shifted from supportive services to nutrition or vice versa. Fifteen percent of the appropriations for the nutrition program for the elderly can be reallocated between congregate and home-delivered meals. A single, large lump sum authorization for Title III would make it more difficult to obtain adequate appropriations for supportive and nutrition services. Finally, this approach may pave the way to block grant the entire Older Americans Act to the states. We would oppose this approach because aging-related issues are national in scope and deserve national attention.

B. Surplus Commodities

NCBA favors retention of the surplus commodities program in its present form under the direction of the Department of Agriculture. The current system provides reimbursement on the basis of the meals served. This offers an incentive for nutrition programs, especially those which can leverage funds to qualify for additional reimbursement from the Department of Agriculture. Older Americans have benefited from this arrangement because more meals can be served.

Therefore, NCBA reaffirms its support for continuing the surplus commodities program in the Department of Agriculture, rather than replacing the program by cashing it out with funds alloted to states under a formula.

C. Retain Priority Services

NCBA further urges that area plans continue to include funding for three priority services: (1) in-home, (2) access, and (3) legal services. These are essential services, especially for older minorities.

Current law only requires that "some funds" be expended for each category. The problem, though, is that certain area agencies provide only token amounts, and some nothing at all. A minimum floor should be written into the law to provide adequate funding for legal services. This is uniquely justified for legal services because it is perhaps subject to the greatest political pressure at the community level.

Other governmental units, for example, may urge area agencies on aging not to fund legal services because they do not want to be sued. These facts make it imperative that legal services remain a priority and that they be funded at an adequate level.

D. State Legal Services Developers and State Education and Training

NCBA recommends that state legal services developers be funded out of Title III, instead of section 424 legal services demonstrations. This is more appropriately a state administrative activity. We propose that there be a $1 million cap on evaluating programs under the Older Americans Act, instead of permitting 1 percent of the funds appropriated under the law to be used for this purpose. The current 1 percent ceiling translates to nearly $7 million. This savings could be used to fund the state legal services developers and state education and training activity, which is, in reality, staff development. For this reason, we recommend that state education and training be designated as staff development and funded as such. Appropriate steps should be taken to assure that there is no reduction in funding for either state legal services developers or staff development.

E. Opposition to Converting Title III Into a Long-Term Care Program

NCBA generally supports fine-tuning changes to the Older Americans Act because we favor early enactment of the reauthorization bill. For this reason, we oppose rewriting Title III's supportive and nutrition services to make them more of a long-term care program. We are concerned that Title III would become more diffuse. Moreover, health-related services are among the most expensive under the Older Americans Act. Consequently, this proposal may not provide the community wide benefits that Title III does now.

Today there is much debate about the proper role, structure, and placement of long-term care services in our health care system. All of these issues present thorny questions which are not capable, in our judgment, of early resolution. We think that a better course of action would be to gather essential data and analyze it throughly before acting precipitously by bundling a hodge podge of long-term care related activities into a proposal which may create more problems than it solves.

F. Opposition to the Direct Provision of Services

In general, the Older Americans Act prohibits state and area agencies on aging from providing direct services unless essential to assure an adequate supply of a particular service. Congress included this measure because funding under the Older Americans Act is limited. Consequently, state and local offices on aging have been assigned responsibility for planning, coordinating, and administering programs, as well as leveraging additional funds to build upon Older Americans Act appropriations. This arrangement has generally worked well, and NCBA recommends that it be continued.

IV. TITLE IV TRAINING, RESEARCH AND DEMONSTRATIONS

Several structural and programmatic changes are needed to strengthen Title IV training, research and demonstrations. The single most important goal is to raise the authorization to permit the Congress to provide higher appropriations. Funding for Title IV has been slashed by 59 percent within a two-year period, from $54.3 million in FY 1980 to $22.2 million in FY 1982. Appropriations have been frozen at $22.2 million during FYs 1983 and 1984. The current funding level is nearly equivalent to the FY 1975 appropriation ($23.0 million). The overall inflation rate, however, has jumped by 93.9 percent, from January 1975 to October 1983.

NCBA recommends that funding be raised in increments to $40 million in FY 1985, $45 million in FY 1986, and $50 million in FY 1987.

Strong language should be included in Title IV to promote career preparation training for minorities, especially at historical Black colleges and universities. This is needed to emphasize that career level education for minority group individuals is a high priority under the Older Americans Act. This is essential to attract more minorities into the field of aging.

We also recommend that there be a specific set aside for minority contractors and grantees.

Title IV should establish separate categories for education, training, research, and demonstrations, instead of consolidating these activities under two major components. The scope and purpose of each program should be spelled out clearly and specifically with emphasis upon certain targeted activities. In addition, the role of Title IV should be clarified. One of its major purposes should be to strengthen services and ultimately improve the well being of older Americans.

NCBA favors strong prohibitions against commingling Title IV funds with other Office of Human Development Services programs because this reduces accountability for Older Americans Act funding. A strong prohibition should be written into the law against commingling Title IV funds with other activities. We are not opposed to cooperative funding for projects with similar objectives, but we do resist commingling appropriations for the reasons already given.

Effective requirements for dissemination and reporting should be developed for Title IV to assure that practitioners in the field of aging and others have access to training, research and other work products. Title IV produces numerous exemplary works, such as the equity studies, the minority management training program, and the aging policy centers. But people must know about these activities before there can be any appreciable impact.

V. TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

NCBA strongly supports retaining the Title V SCSEP within the Department of Labor, rather than transferring it to the Department of Health and Human Services or any other agency.

Title V is an employment program and is, therefore, more appropriately administered by the Department of Labor. Congress gave careful consideration to the proper placement of a senior jobs program when it created the SCSEP. After much deliberation, a decision was made, with virtually unanimous support, to have the Department of Labor administer the national senior service corps, and not AoA. The reasons for that decision are even more compelling now.

Title V has been an exceptionally effective program, according to independent evaluations, newspaper reports and other accounts. The program has always enjoyed strong bipartisan support. It does not make sense--administratively, politically or otherwise--to break up a winning combination. There is an old saying that people should not try to fix something when it is not broken. This certainly applies to the administration of the SCSEP by the Department of Labor.

The proposed transfer of Title V to HHS would also cause serious problems for older Blacks. First, the recommended authorized funding in fiscal year 1984 would cause more than 10,000 enrollees to lose their jobs because it is $52.35 million below the current appropriation. Approximately 21 percent of all SCSEP enrollees are Black. Applying this same ratio, about 2,100 low-income older Blacks would become unemployed if this measure became law.

Second, the proposal would change the funding formula, which would be disruptive for older Blacks. Title V funds are now allocated on the basis of a two-factor formula: (1) per capita income and (2) population 55 or older. The proposal would award funds starting in 1985 on the same elderly-population-based formula (persons 60 and above) that exists for Title III supportive and nutrition services. A 60-plus population formula does not make sense for a program serving low-income persons 55 or older. Older Blacks would probably be victimized under this formula since they tend to be concentrated more in states with lower per capita income, especially in the rural South. Many of these states would be losers under a switchover to a 60-plus formula.

NCBA also favors at least a three-year extension of Title V and other programs under the Older Americans Act. This is crucial for planning purposes. Moreover, it will provide greater continuity of effort, which can prevent disruptive starts and stops.

NCBA further recommends that authorized funding for Title V be boosted to permit more low-income older persons to participate in the program. Currently, 62,500 positions are authorized. We urge that there be sufficient funding to provide 70,000 slots in FY 1985 and eventually 85,000 by FY 1987.

VI. CONCLUSION

In conclusion, all Americans should have an interest in assuring that the Older Americans Act is built on a solid foundation. NCBA's comprehensive proposals will help to strengthen and improve the Older Americans Act for elderly Blacks and other persons. We also urge that the Congress act expeditiously in considering the reauthorization legislation.

Ideally, a bill should be sent to the President by mid May. This is crucial to prevent any snafus which can tie up this legislation. Additionally, early action is necessary to provide an appropriation for Older Americans Act programs. No one wants the act to limp along under a continuing resolution.

Questions for Samuel Simmons from Senator Charles Grassley

1. I would like to ask you the same question I asked the preceding panel: namely, whether you make any effort to track enrollees who move into private employment?

If you do, can you summarize for us what your conclusions are?

2. Can you tell us what the average annual income of your Title V enrollees was in fiscal year 1983?

The National Caucus and Center on Black Aged, Inc.
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Hobart C. Jackson
Founder, NCBA - 1970
(1916-1978)
Dr. Aaron E. Henry
Chairman
Samuel J. Simmons
President

April 26, 1984

MAY - - 1984

Honorable Charles E. Grassley
Chairman, Subcommittee on Aging
United States Senate
Senate Hart Building
Room 135
Washington, DC 20510

Dear Senator Grassley:

Thank you for the opportunity to testify before the Senate Subcommittee on Aging regarding Title V of the Older Americans Act. I also welcome your invitation to respond to further questions for the record.

In response to the questions posed in your April 23, 1984 letter, I am pleased to present the following information:

1. The National Caucus and Center on Black Aged does track the Title V enrollees who leave the program at the 30, 60 and 90 day point after their termination. This tracking includes all enrollees regardless of the reason for their termination. The results of this tracking for the current program year (July 1, 1983 through April 13, 1984) indicate that well over 95% of the persons who were placed into unsubsidized employment from the program remained employed 90 days after the placement was made. Due to lack of resources we do not track the enrollees beyond the 90 day period, however since we do inform the enrollees who are placed that they have priority to return to the program if the unsubsidized position does not last, we feel sure that the placements are proving to be permanent since only 3 of the 197 placements we have made this year have applied for re-enrollment in the program.

Of the 197 persons who were placed into unsubsidized employment so far this year the average annual family income upon enrollment was $3,511, and the average annual income of these persons after placement was $10,644 for an increase of the average annual family income of $7,133.

2. The average family income of all the enrollees we have enrolled in the program during the current program year is $3,489. Over 85% of our enrollees have family incomes below the actual poverty level and less than 15% have incomes between the poverty level and the 125% level allowed for participation in the program.

The average age of our enrollees this year is 63 and the average educational attainment is 9th grade. 72% of our enrollment is minority and 28% is white.

3. The enrollee positions in the NCBA Senior Employment Program are assigned on a county basis in each state we operate in based on the number of eligibles in each county compared to the number of eligibles in the entire state. This assignment takes into account other Title V program operators to help assure that each county within a state, to the maximum extent feasible, has the fair proportional share of the enrollee positions available in the state. We also attempt to spread the enrollee positions throughout the communities we operate in. The average number of enrollees we have at host agencies is 3 and we have very few agencies that are assigned more than 10 enrollees.

I would like to repeat my appreciation for the opportunity to testify before the Subcommittee and thank you and the rest of the Subcommittee members for your committment to the employment needs of older persons.

Sincerely,

Samuel J. Simmons
President

Senator GRASSLEY. Thank you. Let me apologize for the noise in the background. I was able to hear everything you could say, but I might ask you, Dr. Glasgow, if you would speak into the microphone even if it sounds a little loud just to cover the time when they will be hammering.

Dr. GLASGOW. Thank you, Mr. Chairman. I am Doug Glasgow, vice president for Washington operations of the National Urban League. It is a special pleasure to appear before the subcommittee to discuss title V of the Older Americans Act and the Urban League's experience particularly in regard to this program.

The National Urban League, as you well know, is a nonprofit community service organization which is dedicated to securing equal opportunity for blacks, the poor, and other disadvantaged individuals in all sectors of our society.

Through our network of 113 affiliates in 35 States and the District of Columbia, we deliver social services to the needy in the Nation's cities. Twenty-three of these affiliate offices are presently providing training and placement assistance through the seniors program.

The National Urban League is particularly pleased to be able to provide the services afforded by title V because the 2.8 million black elderly in the United States are a significant portion of our constituency. Not only are these individuals burdened as a result of their minority status, but they also suffer the generic hardships of being aged. According to the 1980 census, the black elderly are three times as likely as their white counterparts to suffer from poverty, poor health and inadequate health care, substandard housing, and crime.

At the root of, or at the very least aggravating these conditions is the income status of older black Americans. Thirty-eight percent of those 65 years and older have incomes below the poverty level, versus 14 percent of comparable white populations. The median family income for an elderly black married couple was $7,293 in 1980, and in female-headed households was only $6,662. And over one-half of the elderly black population below the poverty level fell into the latter category. Clearly, the need for assistance to this population is great.

The title V program is a particularly effective response to the needs of the black elderly because it is targeted and it provides earned income for many for the first time in their lives; fulfills unmet community needs and offers services to many of the participants' peers.

Enrollees in the Urban League Program are 74 percent minority; 73 percent are female; 65 percent are 60 years and older; and 88 percent are at or below the poverty level. We have consistently been able to meet and often surpass the goals established by the Congress and the Department of Labor for the program, as demonstrated by some highlights of our program for the 2-year period ending June 30, 1983.

An average quarterly enrollment of 1,014 was maintained, which exceeded our established goal by 168. Four hundred and forty-eight individuals—that is, a 23-percent average for 2 years—were placed in unsubsidized jobs, meeting 154 percent of the unsubsidized placement goal.

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Of the 23 percent placed in unsubsidized jobs, 91 percent were in the private sector, both for nonprofit agencies, and self-employment. A wide variety of techniques have been used to identify available jobs, including studies of employer attitudes, direct marketing, employer workshops, and other forums.

These steady improvements and accomplishments in the seniors program have been recognized by Congress many times over: through the override of the President's veto of the General Supplemental Appropriations bill in 1982 which contained title V funding; again in the fiscal year 1983 continuing resolution which secured the program through June 30, 1984; and most recently by including the seniors program in the 1983 emergency jobs bill.

These votes of confidence have been encouraging and have allowed us to continue to deliver needed training and placement services to the aged. In fact, the additional funding provided under the jobs bill allowed the Urban League to expand the number of cities we serve from 15 to 23.

The funding was smoothly and effectively incorporated into our program, and is presently providing employment and training assistance to more than 1,000 additional individuals. This was money obviously well spent, and we hope that we can count on this continued commitment to title V.

The need for assistance has in no way been diminished, however, and there is no shortage of eligible applicants. Rather, in many of our cities there are waiting lists of people anxious to participate in the program. Only a lack of funds prevents us from including them.

Given the magnitude of the need, coupled with the SCSEP's effectiveness and efficiency, it would seem reasonable at least to bring the fiscal year 1984 authorization up to the existing level of $319.45 million. Without this restoration, we will be forced to reduce the number of slots as of July 1 of this year. We do not wish to do that.

In light of title V's track record, and the severity of the unemployment problem among this Nation's elderly, this would seem at best incongruous.

The type of gainful employment provided by the seniors program is clearly one of the best ways to assist the elderly who are so often on fixed incomes. With the added income provided by these jobs, the aged are given a measure of security not available to so many others.

Consequently, it is essential that title V remain in the Department of Labor so that it does not lose its employment focus. Title V was never intended to be, nor should it be housed in the agency that would suggest that it is an income maintenance program.

Further, no other agency has demonstrated the capability to replicate DOL's success.

In concluding, I would like to suggest, Mr. Chairman, that Congress has always seen fit to do this in the past and we would urge that you continue this tradition to support title V. The program's success more than recommends that it be continued. I would hope that the seniors program could be expanded to magnify its accomplishments, extend the benefits to more of the needy, and bring hope and fulfillment to this Nation's older Americans.

Thank you very much.

[The prepared statement of Dr. Glasgow and responses to questions of Senator Grassley follow:]

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For Washington Operations

TESTIMONY

OF

DR. DOUGLAS G. GLASGOW

VICE PRESIDENT FOR WASHINGTON OPERATIONS

NATIONAL URBAN LEAGUE, INC.

before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

on

TITLE V OF THE OLDER AMERICANS ACT

Room 430

Dirksen Senate Office Building

Tuesday, March 13, 1984

9:30 a.m.

CONTRIBUTIONS TO THE NATIONAL URBAN LEAGUE ARE TAX DEDUCTIBLE

Testimony of

DR. DOUGLAS G. GLASGOW
Vice President for Washington Operations

NATIONAL URBAN LEAGUE, INC.

Before the
Senate Committee on Labor and Human Resources
Subcommittee on Aging

on

TITLE V OF THE OLDER AMERICANS ACT

Room 430
Dirksen Senate Office Building

Tuesday, March 13, 1984

Good morning. I am Douglas G. Glasgow, Vice President for Washington Operations of the National Urban League. It is a pleasure to appear before this subcommittee to discuss Title V of the Older American Act, and the Urban League's experiences with this program.

The National Urban League is a non-profit community service organization dedicated to securing equal opportunities for blacks, the poor, and other disadvantaged individuals in all sectors of our society. Through our network of 113 affiliates in 35 states and the District of Columbia, we deliver social services to the needy in the nation's cities. Twenty-three of these affiliate offices are presently providing training and placement assistance through the Seniors in Community Service Employment Program (SCSEP).

The National Urban League is particularly pleased to be able to provide the services afforded by Title V because the 2.8 million black elderly in the United States are a significant portion of our constituency. Not only are these individuals burdened as a result of their minority status, but they also suffer the generic hardships of being aged. According to the 1980 census, the black elderly are three times as likely as their white counterparts to suffer from poverty, poor health and inadequate health care, substandard housing, and crime. At the root of, or at the very least aggravating these conditions, is the income status of older black Americans. Thirty-eight percent of those 65 years and older have incomes below the poverty level, versus 14 percent of the comparable white population. The median family income for an elderly black married couple was $7,293 in 1980, and in female-headed households was only $6,662. Over one-half of the elderly black population below the poverty level fell into this latter category. Clearly, the need for assistance to this population is great.

The Title V program is a particularly effective response to the needs of the black elderly because it is targeted; provides earned income, for many for the first time in their lives; fulfills unmet community needs; and offers services to many of the participants' peers. Enrollees in the Urban League program are 74 percent minority, 73 percent are female, 65 percent are 60 years and older, and 88 percent are at or below the poverty level. We have consistently been able to meet and often surpass the goals established by the Congress and the Department of Labor for the program, as demonstrated by some highlights of our program for the two year period ending June 30, 1983:

- An average quarterly enrollment of 1014 was maintained, which exceeded our established goal by 168. A total of 2,267 participants were served over the course of the funding period.
- 448 individuals (a 23% average for two years) were placed in unsubsidized jobs, meeting 154% of the unsubsidized placement goal; 22.2% and 23.7% were placed into unsubsidized jobs during the 1981-82 and 1982-83 program years respectively.
- Of the 23 percent placed in unsubsidized jobs, 91 percent were in the private sector, both for and non-profit agencies, and self-employment.
- The average hourly wage for individuals in unsubsidized jobs was $4.25; while for those in subsidized placements it was $3.39.
- The above-mentioned 448 individuals earned an average annualized wage of $6,464, which represents an increase of $2,959 over their annual subsidized wages while participating in SCSEP.
- A wide variety of techniques are used to identify available jobs, including studies of employer attitudes, direct marketing, employer workshops, public service announcements, and utilization of Urban League board members.
- Similarly, many vehicles are employed to prepare participants for work, such as employability workshops, assistance with resume preparation, self-directed job searches, and ongoing evaluations.
- Medical examinations were provided to 2,911 participants, of which 1,565 were annual examinations.
- ELDERHOSTEL scholarships were awarded to 64 participants.

These steady improvements in and accomplishments of the SCSEP have been recognized by the Congress many times over: through the override of the President's veto of the General Supplemental Appropriations bill in 1982 which contained Title V funding; again in the Fiscal Year 1983 continuing resolution which secured the program through June 30, 1984; and most recently by including the

Seniors program in the 1983 Emergency Jobs bill. These "votes of confidence" have been encouraging, and have allowed us to continue to deliver needed training and placement services to the aged. In fact, the additional funding provided under the jobs bill allowed the Urban League to expand the number of cities we serve from 15 to 23. The funding was smoothly and effectively incorporated into our program, and is presently providing employment and training assistance to more than 1,000 additional individuals. This was money obviously well spent, and we hope that we can count on this continued commitment to Title V.

The need for assistance has in no way been diminished, however, and there is no shortage of eligible applicants. Rather, in many of our cities there are waiting lists of people anxious to participate in the program. Only a lack of funds prevents us from including them. Given the magnitude of the need, coupled with SCSEP's effectiveness and efficiency, it would seem reasonable to at least bring the Fiscal Year 1984 authorization up to the existing level of $319.45 million. Without this restoration, we will be forced to reduce the number of slots as of July 1 of this year. In light of Title V's track record, and the severity of the unemployment problem among this nation's elderly, this would seem at best incongruous.

The type of gainful employment provided by the SCSEP is clearly one of the best ways to assist the elderly who are so often on fixed incomes. With the added income provided by these jobs, the aged are given a measure of security not available to so many others. Consequently, it is essential that Title V remain in the Department of Labor so that it does not lose its employment focus. The program's mandate has always been, and should continue to be, to provide disadvantaged senior citizens with the skills and jobs that will lead to self-sufficiency. The Department of Labor, with its employment and training network in place, is best suited to continue its role. The Department has continually demonstrated an ability to administer the program capably and effectively, keeping administrative costs to an absolute minimum so that more funds can be channeled directly to the older worker. Title V was never intended to be, nor should it be housed in an agency that would suggest that it is an income maintenance program. Further, no other agency has demonstrated the capability to replicate DOL's success, rendering even the contemplation of a move ill-advised and unnecessary.

What the SCSEP does need now is the security that a three year reauthorization of the Older Americans Act would provide. Title V has proven, during its almost six years in existence, to be an exemplary employment program that deserves to continue without interruption or careless tampering. The Congress has always seen fit to do this in the past, and I would urge that you continue this tradition. The program's successes more than recommend that it be continued; I would hope that the SCSEP could be expanded to magnify its accomplishments, extend the benefits to more of the needy, and bring hope and fulfillment to this nation's older Americans.

Questions for Douglas Glasgow from Senator Charles Grassley

1. I would like to ask you the same question I asked the preceding panel: namely, whether you make any effort to track enrollees who move into private employment?

If you do, can you summarize for us what your conclusions are?

91216

The National Urban League provided to the Subcommittee in response to this question its most recent quarterly report for its Title V program. The Urban League also provided a report on their demonstration project, Seniors in the Private Sector. This material is available for inspection in the Subcommittee office, 404 Hart Senate Office Building, 2nd and Constitution Streets, N.E., Washington, D.C. 20510.

Senator **Grassley**. Thank you. You remember I said that we had many faithful members who came to these hearings on the Older Americans Act. Senator Pell has been one of those, and he is here again.

If you are under constraint of time, I would be glad to defer to you. I have already asked these people the questions they are going to respond to because this is the second panel.

Senator **Pell**. Thank you very much. I just wanted to come and wish you well and thank you for conducting these hearings, and get the flavor of the hearings. I look forward to reading their testimony in the record. Thank you very much.

Senator **Grassley**. Thank you.

Before I go to you, David, I would like to go back to your testimony. You gave us some figures along the lines of what I had previously inquired about, but I did not get from the testimony—are those over a long period of time or are those for a very recent year?

Dr. **Glasgow**. I think they are a combination.

Senator **Grassley**. A combination of several years?

Dr. **Glasgow**. Correct.

Senator **Grassley**. OK.

David, would you go ahead, then, and respond? Why don't you respond to all the points that I raised. Then we will go on to Mr. Simmons to respond to all the questions?

Mr. **Affeldt**. I would be delighted. Could I just make a quick summary of the Asociacion's statement since they did submit a statement for the record and they were asked to testify?

Senator **Grassley**. Oh, yes. I am sorry.

Mr. **Affeldt**. That is all right. The Asociacion has a longer statement which I will ask to insert in the record.

[The prepared statements of the Asociacion Nacional Pro Personas Mayores follow:]

ANPPM
ASOCIACION NACIONAL PRO PERSONAS MAYORES

TESTIMONY BY

CARMELA G. LACAYO
PRESIDENT/EXECUTIVE DIRECTOR
ASOCIACION NACIONAL PRO PERSONAS MAYORES

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ON

THE TITLE V

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM REAUTHORIZATION

MARCH 13, 1984

REGIONAL CENTERS Los Angeles CA Miami FLA Washington DC New York NY

National Association For Hispanic Elderly
National Executive Offices: 1730 W. Olympic Blvd., Suite 401, Los Angeles, CA 90015 (213) 487-1922

THANK YOU VERY MUCH. THE ASOCIACION IS PLEASED TO TESTIFY AT THIS OLDER AMERICANS ACT REAUTHORIZATION HEARING ON THE TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP). AS YOU HAVE REQUESTED, WE SHALL KEEP OUR STATEMENT BRIEF. WE REALIZE THAT YOUR TIME IS LIMITED. HOWEVER, WE WOULD LIKE TO SUBMIT A LONGER AND MORE COMPREHENSIVE STATEMENT IN THE HEARING RECORD.

WE HAVE TWO MAJOR POINTS THAT WE WISH TO MAKE, AND THEN WE SHALL BE GLAD TO RESPOND TO ANY QUESTIONS FROM THE SUBCOMMITTEE.

TITLE V SHOULD REMAIN IN THE LABOR DEPARTMENT

FIRST, THE ASOCIACION FAVORS RETENTION OF THE TITLE V SCSEP IN ITS PRESENT FORM. THERE IS AN OLD SAYING THAT PEOPLE SHOULD NOT TRY TO FIX SOMETHING WHEN IT IS NOT BROKEN. THIS ADAGE IS VERY APPROPRIATE FOR TITLE V.

THE SCSEP HAS BEEN CLOSELY MONITORED BY THE CONGRESS, INDEPENDENT EVALUATORS, THE NEWS MEDIA, AND OTHERS. THE VERDICT IS VIRTUALLY UNANIMOUS: TITLE V HAS BEEN AN EXCEPTIONALLY EFFECTIVE PROGRAM. ADMINISTRATIVE COSTS HAVE BEEN KEPT LOW, ALLOWING MORE FUNDS TO GO DIRECTLY TO TITLE V PARTICIPANTS. PRACTICALLY EVERY DOLLAR SPENT FOR OUR PROGRAM, PROJECT AYUDA, HAS BENEFITTED OLDER WORKERS DIRECTLY -- IN TERMS OF WAGES, FRINGE BENEFITS, AND ADDITIONAL SERVICES.

WITHOUT TITLE V, MANY OF THESE INDIVIDUALS WOULD BE FORCED TO DEPEND UPON PUBLIC ASSISTANCE. BUT THE SCSEP PROVIDES A DIGNIFIED AND COST-EFFECTIVE MEANS TO IMPROVE THEIR WELL-BEING WHILE ENABLING THEM TO MAKE A VALUABLE CONTRIBUTION TO THEIR COMMUNITIES AT THE SAME TIME.

TITLE V HAS WORKED WELL IN THE DEPARTMENT OF LABOR. FOR THIS REASON, WE STRONGLY FAVOR RETENTION OF THE PROGRAM IN THE LABOR DEPARTMENT. A SHIFT AT THIS TIME WOULD ONLY CAUSE GREAT DISRUPTION FOR TITLE V ENROLLEES, PROGRAM ADMINISTRATORS, AND THE HOST AGENCIES SERVED BY THE SCSEP. WE ALSO BELIEVE THAT THE LABOR DEPARTMENT SHOULD ADMINISTER TITLE V BECAUSE IT IS AN EMPLOYMENT PROGRAM. THE LABOR DEPARTMENT HAS PRIMARY RESPONSIBILITY FOR WORK AND TRAINING PROGRAMS AND ALREADY HAS A NETWORK IN PLACE TO ASSIST TITLE V IN BECOMING EVEN MORE EFFECTIVE AND SUCCESSFUL THAN IT CURRENTLY IS.

INCREASED AUTHORIZATION LEVELS

SECOND, THE ASOCIACION URGES THE SUBCOMMITTEE TO APPROVE INCREASED AUTHORIZATION LEVELS TO PERMIT MORE LOW-INCOME PERSONS AGED 55 OR OLDER TO PARTICIPATE IN THE SCSEP. OUR EXPERIENCE WITH TITLE V PROVIDES CLEAR AND CONVINCING EVIDENCE THAT THERE ARE NUMEROUS AGED HISPANICS AND OTHER OLDER AMERICANS WHO ARE READY, WILLING AND ABLE TO PARTICIPATE

IN TITLE V. SOME OF OUR PROJECTS PURPOSEFULLY DO NOT PUBLICIZE THE PROGRAM AS MUCH AS THEY COULD, PRIMARILY TO AVOID RAISING HOPES WHEN NO REALISTIC PROSPECTS EXIST FOR A JOB. OUR PROJECTS THROUGHOUT THE COUNTRY FREQUENTLY HAVE SEVERAL APPLICANTS FOR EACH AVAILABLE POSITION. THERE WOULD CLEARLY BE MORE IF THE PROJECTS DID MORE ADVERTISING. BUT, THEY WOULD ONLY CREATE FALSE HOPES THAT WOULD NOT BE FULFILLED.

A BOOST IN THE AUTHORIZATION IS ALSO JUSTIFIED SINCE TITLE V COSTS HAVE INCREASED IN RECENT YEARS AND WILL RISE IN THE YEARS AHEAD BECAUSE:

-- WORKER COMPENSATION COSTS HAVE INCREASED SHARPLY IN RECENT YEARS.

-- THE FEDERAL UNEMPLOYMENT TAX RATE ROSE IN JANUARY 1983 FROM 3.4% TO 3.5%, AND THE TAXABLE WAGE BASE JUMPED FROM $6,000 TO $7,000.

-- SOCIAL SECURITY TAXES HAVE RISEN. PAYROLL TAXES WILL INCREASE SIGNIFICANTLY IN THE YEARS AHEAD BECAUSE OF THE 1983 SOCIAL SECURITY ACT AMENDMENTS. IN FISCAL YEAR 1984, THERE WILL BE TWO SOCIAL SECURITY TAX HIKES, FROM 6.7% TO 7.0% IN JANUARY 1984 AND THEN TO 7.05% NEXT JANUARY.

AN EXPANDED TITLE V IS ALSO NEEDED NOW MORE THAN EVER BECAUSE POVERTY IS ON THE RISE FOR OLDER AMERICANS, AND ESPECIALLY

FOR WORKERS IN THE 55-TO-64 AGE CATEGORY. POVERTY INCREASED BY 114,000 FROM 1981 TO 1982 FOR INDIVIDUALS 55 TO 64 YEARS OLD, FROM 2,211,000 TO 2,325,000. SOME PERSONS ESCAPED THE GRIP OF POVERTY BY OPTING FOR EARLIER SOCIAL SECURITY BENEFITS. HOWEVER, THEIR MONTHLY PAYMENTS WILL BE ACTUARIALLY REDUCED FOR THE REST OF THEIR LIVES.

POVERTY INCREASED BY MORE THAN 5% FOR HISPANICS 55 OR OLDER DURING THIS PERIOD, FROM 298,000 IN 1981 TO 314,000 IN 1982. AGED HISPANICS AND OTHER OLDER AMERICANS ARE DISCOVERING THAT THEY ARE AMONG THE LAST TO BE HIRED DURING THE RECENT IMPROVEMENT IN OUR OVERALL JOBS PICTURE. IT IS QUITE LIKELY THAT THIS PATTERN WILL CONTINUE IN THE FUTURE BECAUSE UNEMPLOYMENT WILL STILL PROBABLY REMAIN HIGH BY HISTORICAL STANDARDS.

CONCLUSION

OVER THE YEARS, THE SCSEP HAS DEMONSTRATED THAT THERE ARE MANY LOW-INCOME OLDER AMERICANS WHO WANT AND NEED TO WORK IN THEIR COMMUNITIES. TITLE V IS THE MOST EFFECTIVE EMPLOYMENT PROGRAM EVER ENACTED FOR ELDERLY PERSONS, AND IS PERHAPS THE MOST EFFECTIVE JOBS PROGRAM EVER.

THE SCSEP DESERVES TO BE CONTINUED FOR AT LEAST THREE YEARS. THE PROGRAM SHOULD BE INCREASED TO MEET THE CHALLENGE AHEAD. FINALLY, TITLE V SHOULD REMAIN IN THE LABOR DEPARTMENT, WHERE IT HAS FUNCTIONED SO EFFECTIVELY SINCE ITS CREATION IN 1973.

ANPPM
ASOCIACION NACIONAL PRO PERSONAS MAYORES

TESTIMONY ON

REAUTHORIZATION OF THE OLDER AMERICANS ACT

BY

CARMELA G. LACAYO
PRESIDENT/EXECUTIVE DIRECTOR
ASOCIACION NACIONAL PRO PERSONAS MAYORES

BEFORE THE

HOUSE SELECT COMMITTEE ON AGING

NOVEMBER 28, 1983

LOS ANGELES, CALIFORNIA

REGIONAL CENTERS Los Angeles, CA Miami, FLA Washington, DC [illegible]

National Association For Hispanic Elderly

Congressman Roybal and Members of the House Committee on Aging, the Asociacion Nacional Pro Personas Mayores welcomes the opportunity to testify at your hearing today in Los Angeles. We also wish to commend you for conducting a hearing on reauthorization of the Older Americans Act at this early date.

The Asociacion has always strongly supported the Older Americans Act. We, however, believe that the Act can be made more responsive to the needs of older Hispanics and other low-income minorities. The recent Civil Rights Commission report provides compelling evidence that older Hispanics and other aged minorities are underserved.

Economic Status of Older Hispanics

The Asociacion has a comprehensive list of recommendations to strengthen the Older Americans Act. First, however, we wish to provide the Committee with a brief demographic summary about older Hispanics today. This will provide a foundation for our policy proposals to perfect the Older Americans Act.

All elderly persons are members of a minority group in one real sense -- they represent 11% of our total population. Between 1970 and 1980 the number of Hispanics aged 65 and over increased tremendously: from 408,000 in 1970 to 708,800 in 1980, or 75 percent. This growth rate far exceeds the 25 percent growth rate for older Whites and the 34 percent increase in the older Black population between 1970 and 1980.

Older Hispanics in California officially numbered 179,307 in 1980 -- 7.4% of California's total older population. (Of course, the acknowledged undercount of Hispanics in the past two national censuses no doubt understates the true figures.) As a group the elderly share many common problems and concerns:

coping with reduced income, mounting health care costs, housing problems, and transportation inadequacies. These problems are frequently intensified for older Hispanics. In a very real sense they experience triple jeopardy because they are old, poor, and a minority within a minority. In addition, Hispanics suffer from an added barrier -- language.

Many Anglos were never poor until they became old. A substantial number of the Hispanic elderly, though, have known poverty throughout their lives -- from the moment of birth until death. Old age simply confirms the inevitable for them: a life of misery and deprivation with no realistic hope to escape.

A recent Census Bureau report provides further documentation that the quality of life for older Hispanics is substantially below that for the Anglo aged by practically any standard of measurement. Poverty increased by 13,000 for Hispanics 65 or older in 1982, but declined by 102,000 for all aged persons. About 159,000 aged Hispanics were poor in 1982, approximately one out of every four (26.6%) Spanish-origin individuals 65 or older. This level is the second highest ever recorded, since the Census Bureau first began tabulating poverty data about older Hispanics.

Aged Spanish-origin persons are more than twice as likely to be poor as elderly Anglos. In 1982, 26.6% of all aged Hispanics nationwide lived in poverty, compared to 12.4% for elderly Whites.

Poverty likewise prevails among older Hispanics in Los Angeles. According to a 1981 needs assessment of older persons by the County of Los Angeles

Area Agency on Aging, older Hispanics had more problems with low income than any other group. The $7,567 average annual per capita income among the elderly in Los Angeles' third supervisorial district (which includes the largest concentration of older Hispanics) is the lowest in the county.

Poverty is a rock bottom existence, under the Census Bureau definition. Persons 65 or older were considered poor in 1982 if their annual income did not exceed $4,626 ($5,836 for an elderly couple). This translates to $89 per week ($112 for aged couples) to pay for housing, food, health care, transportation, clothing, utilities and other everyday necessities.

The poverty figures -- depressing as they may be -- represent only a portion of a grim economic picture for older Hispanics. Another 85,000 are marginally poor. Their incomes barely exceed the poverty thresholds, but not by more than 25%. The net impact is that 244,000 older Hispanics -- about two out of every five Spanish-origin persons 65 years of older -- either live in poverty or so close to it that they really cannot appreciate the difference.

These statistics, though, do not fully depict the dimensions of the retirement income crisis gripping thousands of older Hispanics and threatening to engulf more. Many older persons, for example, are not includud in the poverty or near-poverty figures because the Census Bureau significantly undercounts Hispanics. Additionally, older Hispanics with income below the poverty or near-poverty thresholds are not counted for Census purposes if they live with others with sufficient incomes to boost them above these economic floors.

These statistics underscore the need to make the Older Americans Act more responsive to the unique and growing problems confronting older Hispanics.

General Principles

The Asociacion urges the Committee to consider three fundamental general principles in extending the Older Americans Act.

Three-Year Reauthorization: First, all Older Americans Act programs should be extended for at least three years, through FY 1987. Congress has traditionally approved three-year extensions. This permits program administrators to plan their activities with adequate lead time. At the same time, a three-year extension enables the Congress to review the programs periodically.

A three-year extension also provides greater continuity for Older Americans Act programs, which can prevent disruptive starts and stops. The value and worth of the Older Americans Act have been amply demonstrated over the years. Legislation as successful and effective as the Older Americans Act deserves to be continued for at least three years, and preferably for five years.

Increased Authorizations: Second, funding levels should be raised to more adequate levels across the board for all programs. Currently, the FY 1984 appropriation for AoA activities in $674.2 million. This represents about $18 for every person 60 years or older in the U.S.

Clearly a nation -- with the greatest resources in history -- can do a better job for its senior citizens. The Asociacion has further specific recommendations to make about authorizations -- especially for Title IV and V -- and I shall have more to say about that later.

Quick Action With Fine Tuning Changes: Third, the Asociacion favors prompt action on the Older Americans Act reauthorization -- preferably by May 1, 1984. If the measure can be signed into law early, Older Americans Act programs can be funded under an appropriations bill, rather than a continuing resolution.

Fast action is also imperative because the Democratic and Republican Conventions will be held next summer. If the reauthorization legislation is not considered by May, the bill could be snagged in a legislative logjam.

For these reasons, the Asociacion backs early action on the reauthorization legislation with basically fine tuning changes.

Improving Services and Opportunities for Minorities

Last year's report by the Civil Rights Commission plus earlier equity studies conducted for AoA make it clear that older minorities have not been adequately served under the Older Americans Act, and particularly Title III. In fiscal year 1982, aged minorities received 17.5% of the supportive services under Title III-B, 18.0% of the congregate meals and 20.2% of the home-delivered meals. The Hispanic participation rate ranged from 4.0% to 4.8%.

Overall, minorities received 17.8% of all the services under Title III in FY 1982. This low-level participation rate should be bolstered immediately to 25%, with an ultimate goal of 33-38% by FY 1987.

This target goal is computed as follows: Aged minorities constitute about 13.3 percent of all persons 60 or older in the United States (1980 census). Hispanic and Blacks (information is not available for other minority aged) were 2.8 times as likely to be poor in 1982 as elderly Anglos. About 11.5% older Whites were poor in 1982, compared to 32.3% among Hispanics and Blacks 60 or older. The participation goal is equal to the minority aged proportion of the total 60-plus population multiplied by the relative poverty level for aged minorities compared to older Whites. Thus, the participation goal equals 13.3% multiplied by 2.8, which is 37.2%. We support several action to achieve this target goal.

First, the current language to require state and area agencies on aging to target services to older persons with the "greatest economic or social needs" should be replaced. We urge that a new and stronger standard be incorporated into sections 305(a)(2)(E) and 306(a)(5)(A). Both these sections should spell out clearly that minority, Indian and limited English-speaking persons are priority groups for receiving Title III services. We recommend the following language"

> "[State and area agencies on aging should be required to] provide asurances that minority, Indian, and limited English-speaking individuals will be priority groups for receiving Title III services. Minority, Indian, and limited English-speaking individuals shall receive services on the basis of their need for services after a comprehensive needs assessment is undertaken. A comprehensive needs assessment shall be undertaken expeditiously to assure the prompt implementation of this provision."

Second, affirmative action is needed to promote jobs, training, and contract opportunities for minorities. Minorities have started the race several steps behind Anglos in becoming involved in the field of aging. Now, "catch-up" measures are needed to provide equal access for those wanting to work in the field of aging or serve older Americans.

Currently only 1.8 percent of AoA's staff members are Hispanic. Since lack of minority staff can adversely affect minority participation in service programs, this severe under-representation of minorities must be corrected. How? We recommend that a new subsection 202(d) be inserted in the Older Americans Act. It should read:

> "(d) The commissioner shall consult with and work with state offices on aging, area agencies on aging, national minority aging organizations, and others with specialized expertise to promote affirmatively additional employment and training opportunities in the field of aging for minority group individuals and additional opportunities for service contracts under this act for minority-sponsored enterprises. The commissioner shall establish appropriate target goals with appropriate time tables to promote additional employment and training opportunities in the field of aging for minority groups individuals, additional opportunities for service contracts for minority-sponsored enterprises under this act, and increase service participation levels for older minority groups individuals under this act. The commissioner shall develop and publish appropriate regulations, guidelines and program instructions to implement this subsection and sections 305(a) (2) (E) and 306 (a) (5) (A) (relating to increased service participation levels of older minority group individuals under this act). The commissioner shall collect comprehensive current data to determine the number and percentage of (1)

employment and training positions for minority group individuals at state and local offices on aging and the Administration on Aging, (2) service contracts for minority sponsored enterprises under this act, and (3) service participation levels for older minority groups individuals under this act.

This action should occur after AoA consults with minority aging organizations, state offices on aging, area agencies on aging, and others with expertise.

Third, a monitoring unit should be established within AoA to oversee these provisions and provide assistance for those trying to comply with the objectives. The unit, for example, could work with state and area agencies on aging to assist them in implementing the goals for seving minorities more equitably under the Older Americans Act.

Mr. Chairman, I ask unanimous consent to insert in the hearing record the Asociacion's position paper to strengthen the Older Americans Act for minorities. This document includes suggested statutory language and provides further backup information to augment our testimony.

Separate Authorizations for Supportive Services and Nutrition

The Asociacion supports the continuation of separate authorizations for supportive services, congregate meals and home-delivered meals under Title III. We are concerned that any effort to consolidate these three programs can ultimately pave the way for block granting the Older Americans Act to the states. Congress enacted the Older Americans Act in 1965 because it fully recognized that the problems and challenges of the aged were national in scope. That landmark law created a partnership at all three levels of government -- federal, state and local -- as well as with national aging organizations, colleges and universities and others.

A federal commitment in the field of aging is absolutely essential today, as it was when the Older Americans Act was enacted nearly 20 years ago. The need may be even greater now because our population is becoming older. And, it is likely to intensify in the years ahead because the number of elderly persons in the United States will increase dramatically within the next 50 years.

Priority Services

We also support retention of the three priority services under Title III -- access, in-home, and legal. These are all high priority services which Area Agencies on Aging should fund as a matter of course. But political pressures are often applied to local offices on aging by other governmental units on the power structure within the community to discourage funding of legal services programs.

Legal services are needed now more than ever because many elderly people are forced to fend for themselves when a legal problem arises -- whether it involves litigation, understanding the technicalities of federal programs, or planning their personal affairs. The harsh reality is that large numbers accept injustice or wrong decisions by government bureaucrats because they do not know legal recourse is available. This is particularly true for older Hispanics.

Currently, the law simply requires that Area Agencies on Aging allocate some funds for each of these three priority services. Quite frequently, only a token amount is used for legal services. It is estimated that 15 to 20 percent of the Area Agencies on Aging provide no funding at all for legal services, despite the clear mandate in the Older Americans Act. The Asociacion supports legislation to establish a minimum floor for legal services to guarantee an adequate amount of funding.

Title IV Training, Research and Demonstrations

Major improvements are needed for Title IV training, research and demonstrations to correct damage that has been inflicted on this vital part of the Older Americans Act in recent years. The number one goal is to increase the authorized funding levels to permit a recoupment of the deep cuts in recent years which have crippled Title IV. Funding for Title IV has been slashed by 59% during the past four years, from $54.3 million in FY 1980 to $22.2 million. We recommend that the authorization be raised to $40 million in FY 1985. This would be roughly equivalent to the FY 1981 appropriation.

Adequate funding is essential for Title IV so that the research, training and demonstration activities can complement the services under Title III.

Demonstrations under the Older Americans Act have produced major innovations, including the nutrition program for the elderly, Foster Grandparents, Retired Senior Volunteer Program , and others. Title IV has responded to one of the most critical problems in the field of aging: the need for more adequately trained personnel. In addition, research activities have helped to develop innovative solutions for the elderly's everyday problems and provide information for policymakers.

The Asociacion urges the Committee to back strong language in the reauthorization legislation to prohibit commingling of Title IV funds with other activities. The mixture of Older Americans Act funds with other appropriations reduces accountability. And, it can siphon off scarce funds. We firmly believe that Title IV appropriations should be used for identifiable aging-related activities.

Reporting provisions under Title IV must be strengthened, too. Title IV produces numerous valuable products, but quite often they gather dust. For this reason, the Asociacion supports statutory language to require AoA to submit a detailed annual report to the Congress describing Title IV activities, products and plans.

In addition, the Asociacion supports three measures to make Title IV more responsive to minorities:

1. The Cranston Amendment should be restored. It would promote training to prepare minorities for careers in the field of aging.
2. There should continue to be a preference for demonstration projects serving the needs of low-income, minority, and limited English-speaking individuals. This priority provision is now included in section 422(a)(5), and it should be retained in the 1984 Older Americans Act Amendments.
3. Organizations representing minorities of low-income persons should be exempted from matching requirements under Title IV. A substantial portion of these organizations simply do not have sufficient cash or in-kind resources to make a 25% contribution. We recommend that section 432(a) be amended by adding a sentence at the end to make it clear that organizations representing minorities or low-income individuals are exempt from any Title IV match.

Senior Community Service Employment Program

The Asociacion favors retention of the Title V Senior Community Service Employment Program (SCSEP) in its present form. Title V has been an extraordinarily effective program by any standard one would choose to use. The SCSEP has consistently received high marks from independent evaluators.

Administrative costs have been kept low, allowing more funds to go directly to Title V participants. Practically every dollar spent for our program, Project Ayuda, has benefitted the older worker -- in terms of salaries, fringe benefits, and additional services.

Without Title V, many of these individuals would be forced to depend upon public assistance. But the SCSEP provides a dignified and cost effective means to improve their well-being while helping others in their communities at the same time.

The SCSEP has been in existence as a permanent, ongoing national program since 1973. Title V has had strong bipartisan support during this period. In fact, it is probably the most effective employment program ever developed. Title V has been a striking success for older Americans, the communities they serve, and our Nation.

For these reasons, the Asociacion strongly favors retention of the SCSEP in the Department of Labor, rather than transferring it to the Administration on Aging or any other agency. A shift at this time would only cause great disruption for Title V enrollees, program administrators, and the host agencies served by the SCSEP.

The proposal to transfer the program to AoA has serious flaws. First, the authorization is $277.1 million, which is $52.35 million below the current Title V appropriation. This means that approximately 10,250 Title V enrollees would lose their jobs. Second, the potential $55.4 million set aside (up to 20% of the $277.1 million authorization) for the new proposed self-employment program would fundamentally alter the program, as well as create further disruption. As a practical matter, the $5,000 cap on self-employment grants per qualifying individual ($25,000 for an eligible group) is not realistic to launch an ongoing operation. This inadequate upfront money will almost assuredly guarantee many failures.

The Asociacion believes DOL should continue to administer the program because the SCSEP is an employment program. DOL has primary responsibility for work and training programs and already has a network in place to assist Title V in becoming even more effective and successful than it currently is.

Moreover, AoA should not be saddled with another responsibility -- administering the SCSEP -- when the agency is already thinly staffed to fulfill its present duties. Under the Older Americans Act, AoA has been given responsibility for administering supportive services, nutrition, research, training, and demonstration programs. AoA had one limited experience in administrating an employment program during the mid 1970's -- the Title X emergency jobs law -- but it soon asked to be relieved of this task.

The Asociacion also urges the House Committee on Aging to back an increase in authorized funding levels for Title V to permit more older workers to participate in the program.

Unemployment has improved in recent months, although joblessness is still unacceptably high by historical standards. Older workers, however, have not benefitted. Last month, for example, unemployment dropped by 25,000 for persons 55 or older. However, this was more than offset by a 64,000-person reduction in civilian labor for older Americans. Aged persons have also not shared in the growth in jobs. The number of persons under 55 years old in the civilian labor force has increased by almost 1.1 million from October 1982 to October 1983. But, the civilian labor force has remained essentially the same for people 55 or older, increasing by only 8,000 during the past year.

Our experience with Title V provides clear and convincing evidence that there are numerous aged Hispanics and other older Americans who are ready, willing and able to participate in the SCSEP.

A boost in the authorization is also justified because Title V costs have increased in recent years and will rise in the years ahead because:

-- Worker compensation costs have increased sharply in recent years.

-- The federal unemployment tax rate rose last January from 3.4% to 3.5%, and the taxable wage base increased from $6,000 to $7,000.

-- Social Security taxes have risen. Payroll taxes will increase significantly in the years ahead because of the 1983 Social Security Amendments. In fiscal year 1984, there will be two Social Security tax hikes, from 6.7% to 7.0% in January 1984 and then 7.05% in January 1985.

Conclusion

In conclusion, the Asociacion wishes to thank you again, Congressman Roybal, for holding this timely hearing in Los Angeles. I want to reaffirm that the Asociacion is ready, willing, and able to work with you, your staff, and other Members of the House Committee on Aging to improve the Older Americans Act.

We believe that our recommendations are sound and will strengthen the Older Americans Act. We further urge that they be adopted when the Congress considers the reauthorization bill.

The Asociacion has enjoyed working with you over the years on a wide range of issues. We look forward to a continuing dialog and partnership.

Mr. **Affeldt**. We have essentially two major points which I will try to summarize very quickly. First, the Asociacion favors the retention of the Title V Senior Community Service Employment Program in its present form.

There is an old saying that people should not try to fix something when it is not broken, and this adage is very appropriate for title V. The Senior Community Service Employment Program has been closely monitored by the Congress, independent evaluators, the news media, and others, and the verdict is virtually unanimous: Title V has been an exceptionally effective program.

Administrative costs have been kept low, allowing more funds to go directly to title V participants. The number of slots authorized is about 62,500. However, we would expect probably more than 100,000 people to participate in the program during the 1983–84 program year.

Practically every dollar spent for our program, Project Ayuda, has benefited older workers directly in terms of wages, fringe benefits and additional services. Without title V, many of these individuals would be forced to depend upon public assistance. The Senior Community Service Employment Program provides a dignified and cost-effective means of improving their well-being while enabling them to make a valuable contribution to their communities at the same time.

Second, the Asociacion urges the subcommittee to approve increased authorization levels to permit low-income persons 55 or older to participate in the Senior Community Service Employment Program.

Our experience with title V provides clear and convincing evidence that there are numerous aged Hispanics and other older Americans who are ready, willing, and able to participate in title V.

Some of our projects purposefully do not publicize the program as much as they could, primarily to avoid raising hopes when no realistic prospects exist for a job. Our projects throughout the country frequently have several applicants for each position available, and there would clearly be more if the projects did more advertising, but they would only create false hopes that could not be fulfilled.

A boost in the authorization is also justified since title V costs have increased. Other witnesses have already ticked off some of the reasons and I will summarize them.

Worker compensation costs are clearly rising. The unemployment tax rose from 3.4 percent to 3.5 percent in 1983. The wage base jumped from $6,000 to $7,000. Social Security taxes have risen. In fact, there will be two increases during the 1884–85 program year: 7 percent already in January 1984, and then to 7.05 percent next January. Of course, for the enrollees, there will be a 0.3- of 1-percent credit for 1984.

An expanded title V is also needed now more than ever because poverty is on the rise for older Americans, and especially for workers in the 55–64 age category. Poverty increased about 100,000 for persons 55 or older from 1981 to 1982, and 114,000 for individuals 55–64 years old, from 2,121,000 to 2,235,000.

Some persons escaped the grip of poverty by opting for earlier Social Security benefits. However, their monthly payments will be actuarially reduced for the rest of their lives. Poverty increased by more than 5 percent for Hispanics 55 or older during this period, from 298,000 in 1981 to 314,000 in 1982.

Over the years, the Senior Community Service Employment program has demonstrated that there are many low-income older Americans who want and need to work in their communities. Title V is the most effective employment program ever enacted for elderly persons and is perhaps the most effective jobs program ever.

The Senior Community Service Employment program deserves to be continued for at least 3 years. The program should be increased to meet the challenges ahead. Finally, title V should remain in the Department of Labor where it has functioned so effectively since its creation in 1973.

Thank you, Senator Grassley and Senator Pell.

Senator **Grassley**. Would you like to be the first, then, to start out?

Mr. **Affeldt**. I would be glad to. Now, I believe that you had three questions. The first one dealt with tracking. In response to tracking, Department of Labor regulations require tracking for 90 days, and both of the organizations I represent comply with that requirement.

They do not track beyond 90 days because this is more expensive. It is an added administrative cost, and there is a feeling that this money can be better used for other purposes, such as job development and trying to place older workers in unsubsidized jobs.

Senator **Grassley**. But you could submit to us some information on that tracking for 90 days?

Mr. **Affeldt**. Yes, we will be glad to give you some additional information for the hearing record.

The second question dealt with the notion of the State plans and title V being part of the State plans. My response would be similar to Mr. Reilly's. I am not sure that title V fits so neatly within the State plan concept that is developed under title III.

We feel that the program has basically worked well, and there has been every effort on the part of the organizations that I represent to work with the States in assuring equitable distribution, and the projects are responding to demonstrated needs.

We are certainly very happy to cooperate with the States, but I am not sure at this time that it would be most appropriate to try to incorporate the title V plan within the title III plan.

Senator **Grassley**. I think where the National Association is coming from is that 22 percent of the slots are administered by States, and the dovetailing of the two programs together.

Mr. **Affeldt**. Sure, I understand that.

Senator **Grassley**. OK.

Mr. **Affeldt**. And I can appreciate their desire to do this.

The third question, I believe, dealt with distribution.

Senator **Grassley**. Yes, and particularly the procedure by which that is arrived at; the informality or formality of it; the extent to which there is a record.

Mr. **Affeldt**. I personally have not been involved. That is handled by the people who administer the programs. I represent the organizations on policy, but I can speak from my personal conversations.

Senator **Grassley**. OK.

Mr. **Affeldt**. I would say that it is probably done on a more informal basis. As Mr. Hutton indicated earlier, a plan is developed and, as you know, submitted to the Department of Labor. A number of factors are taken into account in deciding the allocation, such as the ability of States to perform. Also, in the case of minority organizations, the ability of minority organizations to serve particular client groups.

For example, the National Association of Hispanic Elderly makes special efforts to locate projects in States that have larger Hispanic populations because we believe that the organization may have some specialized skills that others would not in terms of being able to work with the Hispanic community. So the Association is located in a number of States that have larger Hispanic populations—Florida, California, and et cetera.

Then I would be glad to provide any additional information for the record.

Senator **Grassley**. Well, probably on that last point, then, the procedure we would appreciate is have the people with your organization who are involved with that aspect of it to maybe submit something to us in writing.

Mr. **Affeldt**. Sure, we shall be glad to do that, Senator Grassley.

Senator **Grassley**. OK. Mr. Simmons.

Mr. **Simmons**. We will submit you a detailed response on all three points.

Senator **Grassley**. Fine.

Mr. **Simmons**. However, in terms of tracking enrollees, we track all enrollees who go off the program and get unsubsidized placements for a period of 6 months, so we could supply you with information on all enrollees for a 6-month period after they go off the program.

In addition to that, we are doing things such as training individuals to be managers of housing for the elderly. In those cases, we would have an ongoing programmatic relationship with those individuals over a period of time because this is part of an upward mobility activity.

In addition to our tracking, it is my understanding that the Labor Department is also doing some kind of longitudinal study at the present time relating to what happens to people in various manpower programs, and we will also take a look at that and see what more we can find out about that.

Second, in terms of the whole question of title V being a part of the State plan prepared by the Office on Aging, we would really have to take a look at that to see how that would more effectively improve the program.

The thing that we are very pleased with is that there is a meaningful consultative process now that goes on in every State where we operate in terms of sitting down with the States as it relates to an equitable distribution formula. For example, we are in the process of doing that now with the States where we operate.

So I would say that the way the system operates within the States today, from our point of view, is just as effective as are the programs that are operated under State plans from the Office on Aging.

In terms of comments about allocation, first of all the number of slots that we get is determined by statute. However, in terms of deciding—for example, the last time around there was a significant increase of what contractor would go to what State.

There was not any question that there was input from the national contractors, but in the end it is the Labor Department that really makes the decision of how many slots go to the various States.

As I had said earlier, within the States where the slots are assigned, that is again done on an equitable distribution basis and it is not something that is static; it is something that they take a look at on a continuing basis and there is give and take.

So I would just say in terms of this whole process that it is a consultative process. There is no procedure now to say that there has to be public input. I know that none of the national contractors, and I am certain that most of the States, would not be opposed to a requirement that there be public input in that whole process because no one has anything to hide.

Senator GRASSLEY. I am not sure that I anticipated in my question that there ought to be public input so much as just a public discussion within the groups involved.

Mr. SIMMONS. You mean internally within each organization, such as discussing it with your employment community and your board of directors, and that kind of thing?

Senator GRASSLEY. No, no; I would only imply the meetings themselves and the extent to which they are open and the things that are decided are a matter of public openness, as opposed to inviting input from the man or woman on the street. I mean, I do not preclude that as maybe a worthwhile thing to be doing, but I do not think that is the center of my question.

Mr. SIMMONS. Yes; I think that everyone connected with this program would be open to more participation than there is at the present time.

Senator GRASSLEY. Yes.

Mr. SIMMONS. I do not think there would be any opposition at all to that.

Senator GRASSLEY. I do not want to discourage that sort of thing. I just wanted to make clear that I do not intend to go that far in my questioning.

Dr. Glasgow.

Dr. GLASGOW. Thank you, Senator Grassley. Let me just return for a moment to your question at the end of my testimony which was concerning the data we have that tracks the progress and movement of some of our participants.

That data as submitted in the testimony covers a 2-year period, which ends June 1983. We have not yet secured data for the 1984 period.

I also would like to say that the questions which you have posed concerning the percentage of aged employed and movement on those specific populations—some of that data, we definitely will pick up.

Although we do not have funds within the program itself for extensive research, we make it a practice in most of our programs to use our research department to do program research so that we have an idea of the effectiveness of all programs in which we participate.

We will be gathering this data and will be very pleased to provide it and any other data that will be helpful to you in tracking. In regard to the issue of the State plans, I have not been privy to them as of yet but we definitely will review it.

Our experience, as reflected in our testimony, is one of great satisfaction with the procedures that we have been using. They have been effective, and we have no question about reviewing that. If it is to be an adjunct to strengthening the program, we surely would support it, but we will review it.

On the last question of the formula of distribution, in that regard, with your last questioning and sense of the public nature of the deliberations that take place, ours have always been rather open and public. We have not really requested the public itself to participate with us, but surely we would have no question at all in moving it.

It is a very fine program. Those of our affiliates which are involved in it feel very comfortable with it. Surely, it is widely discussed within the affiliates themselves where a lot of the administration takes place. But we would have no question at all of opening up the public nature.

Senator **Grassley**. Those are all the questions I have, at least oral. There may be some additional points that I may want to raise in written response, but not at this point. Thanks to all of you for your participation.

Our next witness is a person from the Department of Labor, Patrick O'Keefe, Deputy Assistant Secretary of Employment and Training within DOL. He is accompanied by Paul Mayrand.

Because of the administration's past and present interest in transferring all or part of this program from Labor to HHS, the committee is most interested in your testimony at this time, Mr. O'Keefe, and I would ask you to proceed accordingly.

STATEMENT OF PATRICK J. O'KEEFE, DEPUTY ASSISTANT SECRETARY FOR EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR, ACCOMPANIED BY PAUL MAYRAND, OFFICE OF COMPREHENSIVE EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR

Mr. **O'Keefe**. Good morning, Mr. Chairman. In the interests of time, sir, I will summarize my remarks and submit for the record our full testimony.

Senator **Grassley**. Thank you.

Mr. **O'Keefe**. It is my pleasure and honor today to be accompanied by Paul Mayrand of our Office of Comprehensive Employment and Training. Mr. Mayrand directly is responsible for administering the Senior Community Service Employment Program.

Mr. Chairman, as I am sure testimony has already pointed out, the title V program employs low-income persons in part-time community service jobs. All program participants are age 55 or older.

Participants work for an average of 20 hours a week in a wide variety of community service activities and are paid, on average, about $3.40 an hour.

Over three-fourths of the participants are age 60 or older, and nearly half are 65 or over. Over 60 percent are female; over half have not completed high school; over 80 percent have a family income below the poverty level.

At the present time, the title V program supports 62,500 job opportunities and is funded at a level of $319 million for a 12-month period that ends this June 30. We will begin spending the fiscal year 1984 appropriation of $317 million on July 1, 1984. This will support approximately the same number of job opportunities as we currently have, and the administration is proposing to continue this level in fiscal year 1985.

In the past few years, a substantial effort has been made to move program participants into unsubsidized jobs, primarily jobs in the private sector. As a result of this effort, progressively more workers are being placed into regular jobs, with the rate increasing from 11 percent placed in 1981 to about 19 percent in 1983. As part of our effort to move participants into private sector jobs, the Department has initiated a series of experimental projects which are designed to test new approaches for preparing older workers for placement into the private sector. During the current year, we have about 16 such projects underway.

The title V program is administered in part by national organizations and, in part, by State grants. Appropriations language for program year 1984 has reserved 78 percent of the amount appropriated for the eight national organizations. The remaining 22 percent is provided to the States.

The administration is proposing a 3-year extension of this program. In making this proposal, we are proposing to you one major administrative change. We are recommending that the funds for the State grants portion of the program be transferred to the Department of Health and Human Services, and that authority for the grants be delegated to HHS. In our view, sir, this change will facilitate the operation of the State grant portion of title V by consolidating all grant resources for services to the aging population in one State agency. This will enable the States to plan their programs better and should improve the delivery of services to the elderly.

The Department of Labor will continue to administer the title V grants with the eight national organizations and we anticipate no changes in that portion of the program, which is expected to support about 48,000 participants in 1985, the same level as we had in 1984.

Title V is not the only Department of Labor-funded program that serves older Americans. The Job Training Partnership Act, which became fully operational last October, authorizes training and placement of economically disadvantaged older individuals in employment opportunities with private business concerns. Three percent of each State's training grant allotment under title II of JTPA is reserved for this purpose. This amounts to approximately $57 million for the program year beginning July 1, 1984.

Thank you, Mr. Chairman. This concludes the prepared remarks. We are pleased to answer any questions you might have.

[The prepared statement of Mr. O'Keefe and responses to questions submitted by Senator Grassley follow:]

STATEMENT OF
PATRICK J. O'KEEFE
DEPUTY ASSISTANT SECRETARY OF LABOR
FOR EMPLOYMENT AND TRAINING
BEFORE THE
SUBCOMMITTEE ON AGING
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

March 13, 1984

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to appear before you today to discuss the Department of Labor's activities under Title V of the Older Americans Act and our future plans for this program. Accompanying me today is Paul Mayrand of our Office of Comprehensive Employment and Training, which administers the Title V program.

As you know, the authorization for appropriations for this program expires at the end of this fiscal year. The Administration is proposing a three-year extension of the authorization, through Fiscal Year 1987.

I would like, first, to outline the current scope of the Title V program, also known as the Senior Community Service Employment Program, and then discuss the change we are proposing to make in the way the program is administered at the Federal level.

The Senior Community Service Employment Program employs elderly, low income persons in part-time community sevice jobs. All program participants are age 55 or older. Participants work an average of 20 hours a week and are employed in a wide variety of community service activities such as health care, home repair and weatherization programs, and in beautification, conservation and restoration efforts. They work in schools, hospitals, parks, community centers, and other government and private nonprofit facilities. The participants are paid an average hourly wage of $3.40 in these community service jobs.

The Senior Community Service Employment Program also provides participants with personal and job-related counseling, annual physical examinations, job training, and, in many cases, referral to regular jobs in the competitive labor market.

Over three-fourths of SCSEP participants are age 60 or older, and nearly half are 65 or older. Over 60 percent are female, over half have not completed high school, and over 80 percent have a family income below the poverty level.

At the present time, the SCSEP program supports 62,500 job opportunities and is funded at the level $319.4 million for the 12-month period that ends on June 30, 1984. We will begin spending the FY 1984 appropriation of $317.3 million on July 1, 1984, which will fund approximately the same number of job opportunities. We have proposed to continue this level in FY 1985.

In the past few years, a substantial effort has been made to move program participants into unsubsidized jobs, primarily jobs in the private sector. As a result of this effort, progressively more workers are being placed into regular jobs, with the rate increasing from 11 percent placed in 1981 to over 19 percent in 1983. As a part of our effort to move participants into private sector jobs, the Department has initiated a series of experimental projects which are designed to test new approaches to preparing older workers for placement into private sector jobs. During the current program year, sixteen such projects are underway. The experience and knowledge gained from these projects should lead to further improvement in the transition of participants into private sector jobs. We propose to continue this experimental program during the 1984 program year.

The Title V program is administered in part by national organizations, and in part through State grants. Appropriations language for program year 1984 has reserved 78 percent of the amount appropriated for Title V for eight national organizations. Three of these operate primarily in rural areas--Green Thumb, Inc. (an arm of the National Farmers Union), the U.S. Forest Service, and the National Center on Black Aged. The National Urban League operates primarily in cities, while the National Council of Senior Citizens, the National Retired Teachers Association, the National Council on Aging, and the National Association for Hispanic Elderly operate mainly in urban and suburban areas, and in a few rural areas. Local projects are operated through contracts with local organizations such as agencies on aging or community groups, and through local affiliates of the national organizations.

The remaining 22 percent of the funds is provided to States. These State grant funds are generally administered by the various State Agencies on Aging, which are funded by the

the Administration on Aging of the Department of Health and Human Services.

The Administration is proposing one major administrative change in the Title V program, beginning in Fiscal Year 1985. We are recommending that funds for the State grants portion of the program be transferred to the Department of Health and Human Services and that authority for the grants be delegated to HHS. This change will facilitate the operation of the State grant portion of Title V by consolidating all grant resources for services to the aging population in one Federal agency. This will enable States to plan their programs better and should improve the delivery of services to the elderly.

The Department of Labor will continue to administer Title V grants with the eight national organizations which have operated this part of the program since the mid-sixties. These organizations will operate the program in every State where they are currently functioning. We do not anticipate any changes in that portion of the program, which is expected to support about 48,600 positions in 1985, the same level as in 1984.

Mr. Chairman, as you know, SCSEP is not the only Department of Labor funded employment and training program that serves older Americans. The Job Training Partnership Act (JTPA), which became fully operational last October, authorizes training and placement of economically disadvantaged older individuals in employment opportunities with private business concerns. Three percent of each State's training grant allotment under Title II of JTPA is reserved for this purpose. This amounts to approximately $57 million for the program year beginning July 1, 1984.

Thank you, Mr. Chairman. This concludes my prepared statement. We will be pleased to answer any questions that you or other members of the Subcommittee may have.

Questions for Patrick O'Keefe from Senator Charles Grassley

Question:

"Do you agree with the GAO characterization of the manner in which slots were distributed among States and sponsors in 1983, to the effect that:

The initial meeting between Labor, the sponsors, and the States was not publicly announced; that it was attended only by those parties; that no formal record was kept; and that subsequent aspects of the process down to the time the decisions were made by Labor were not open to the public?"

Response:

The distribution of funds, first among the States, and then among the national sponsors involves several steps, each of which is available for public review.

The appropriated funds are first divided among the States according to the formula found at Section 506 of the Older Americans Act. Once the funding for each State has been determined it is divided so that a portion of each State's share is given to the national sponsors which operate in that State and a portion to the State sponsor. Within each State the national sponsor share of funds is divided based on standards and instructions provided by the Department of Labor to the sponsors. Once the planning level of each sponsor in each State is determined, these sponsors circulate a copy of the preapplication which includes a geographic distribution of positions, to the Single Point of Contact (SPOC) in each State (formerly called the A95 system.) Another copy of the preapplication is sent to the State Office on Aging for their review. Each of these review points may make comments on the application or the locations of subprojects and the distribution of positions.

The purpose of the initial meeting you cite, is merely to facilitate the division of the national sponsor share of funds within each State. This planning meeting does not change the amount of funds available for any State since the amount is statutorily determined by the Act.

Subsequent to the meeting, the Department initiates a rigorous "responsibility review" of the sponsors which considers such factors as documented cases of fraud and abuse, resolution of audit exceptions and performance. Only then does the Department review and negotiate the grant proposal, which includes consideration of comments generated by the SPOC or the aging network.

We are confident that the public, through the formal Single Point of Contact (SPOC) process or the State Office on Aging, has an opportunity to review and comment on the proposed location of projects.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question.

"The issue of coordination between national sponsors and the State units on aging has become more pressing as a consequence of the Job Training Partnership Act (JTPA) which allocates 3 percent of its total monies to the States for older worker programs and much of which is administered by the State units on aging.

Are you actively coordinating the Title V program with the Job Training Partnership Act programs?"

Response:

The ETA has made significant efforts to encourage cooperation and coordination between national and State sponsors and the JTPA sponsors. To encourage coordination, ETA has:

- Assisted public interest groups such as the National Association of Counties and the National Governors' Association in conducting training sessions and developing of JTPA older worker technical guides.
- Has required all Title V grantees to include in their FY'84 plans a description of efforts that will be made to coordinate their projects with JTPA programs (particularly the older worker set aside).

The National Governors' Association conducted a survey to obtain some basic administrative and programmatic information on JTPA programs. Of the 44 States responding, 26 indicated that the 3 percent Older Worker Programs would be administered in conjunction with the Title V Older Americans programs. Some States have involved State Agencies on Aging through participation on task forces and advisory groups. In addition, some States have assigned the 3 percent program's operational responsibilities directly to the State Office on Aging.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question:

"Are you familiar with Section 502(d)(2)?

This section says: The Secretary shall review on his own initiative or at the request of any public or private nonprofit agency or organization, or an agency of the State government, the distribution of programs under this title within the State including the distribution between urban and rural areas within the State. For each proposed allocation of programs within a State, the Secretary shall give notice and opportunity for a hearing on the record by all interested individuals and make a written determination of his findings and decision.

How do you interpret this provision? Does it apply to any aspects of your 1983 allocation of slots?

Have you used this procedure prior to 1983? Can you provide the Committee with documentation of the occasions on which you employed this procedure?"

Response:

The provisions of subsection 502(d)(2) with regard to any equitable distribution of projects within a State apply to projects operated by national organizations, as well as to States, where the Assistant Secretary determines that the operation of these projects is contributing to an imbalance in services among areas within a particular State.

The hearing on the record process applies only to substate "redistributions" involving equitable distribution of programs and not to reallotments of underutilized funds made pursuant to subsection 506(b).

An entity listed in subsection 502(d)(2) can request a review of the distribution of programs within a State, and the Secretary can actually propose a redistribution of programs (which requires an opportunity for a hearing on the record) within a State to meet the equitable distribution requirements.

The provision was not used in the 1983 allocation of slots, nor was it used in prior allocations.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question.

"Do employees of the States and national sponsors still work in the Labor Department on the older worker program? Can you provide to the Committee a record of the individuals from these organizations who have worked in the Department on the program?"

Response:

That arrangement was carried out under the Intergovernmental Personnel Act (IPA). There are no State or national sponsor employees currently working in the Department on the older worker program under the IPA. The following individuals have worked for the Department under that arrangement in the past:

Name		Sponsor	Approximately date of Employment
Ken Hoagland	-	State of Texas	1979
Patsy Strider	-	State of Louisiana	1980
Charles Baker	-	State of Tennessee	1980
Mercedes Winters	-	Raleigh/Durham, N.C. CETA Sponsor	1978
L. M. Wright	-	State of North Carolina	1979
Brenda Lester	-	Green Thumb, Inc.	1980
Richard Redmond	-	National Council on Aging	1981

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question:

"Section 506(a)(2) states that the Secretary shall, to the extent feasible, assure an equitable distribution of activities among the states. Section 506(c) says that the amount apportioned for projects within each State shall be apportioned in an equitable manner.

The GAO report says that Labor has not undertaken a study to determine if the distribution of enrollee positions is done in an equitable manner. Would it be correct to say that you do not know whether slots are distributed in an equitable manner?

The report says that the Department has made efforts to make the distribution more equitable by calling for a plan to be drawn up by all Title V sponsors and submitted to Labor. But the report also states that the Department did not receive many plans from this effort, and that the Department made only minimal use of the plans it did receive."

Response:

The Department has not undertaken a "formal" study to determine if the distribution of the enrollee positions in each State is equitable. However, because of our dealings with project sponsors we are aware that there are inequities in some states. Consequently, through a process of shifting positions and directing sponsors to place new positions in underserved areas we are correcting these deficiencies.

As to your second point regarding the development of plans, the GAO was referring to reports submitted in 1979 which was the first year that sponsors jointly developed equitable distribution charts. The instructions provided to SCSEP sponsors were intended to introduce the concept of joint planning of program resources (location of positions) and to develop cooperative working relationships. This initial instruction emphasized intra-State cooperation among sponsors. With the formative nature of this process in mind, the Department encouraged local and State staff to jointly develop plans for the location of their positions that would meet their mutual needs. While the submittal of plans to the Department was encouraged, it was not mandatory.

As the GAO report also stated, in 1981, the Department sent another instruction to the sponsors. This one was similar to the first but required that plans be sent to the Department. These reports were analyzed by a panel of Federal, State and national sponsor staff. As also mentioned in the recent GAO

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

report, SCSEP sponsors were recently instructed to prepare updated equitable distribution charts. These new charts will be considered in developing plans for the upcoming SCSEP program year and are based on the most recent Census data.

In summary, since 1979 there has been a sustained effort to cooperatively develop equitable distribution plans and more importantly, to implement these plans.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question.

"The Department of Labor awards funds to State agencies other than State Agencies on Aging in 9 States or territories although the 1981 amendments to the Act specified in Section 506 that it was to be State Agencies on Aging that receive the funds.

Why has the Deparment continued to fund other than State Agencies on Aging in these nine States or territories?"

Response:

The procedure utilized each year by the Department is to notify each Governor of the availability of funds and to ask that the Governor designate the State Agency which will administer the program. The Department, provides the funding to the agency designated by the Governor. We believe that the Governors are in a better position than the Federal Government to determine which State agencies are best equipped to administer this program. Currently, there are only 6 administering State agencies which are not State Offices on the Aging, they are: Minnesota, Oklahoma, Wyoming, Hawaii, Virgin Islands and Guam.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question.

"You stated that the $317 million which you will start spending on July 1, 1984, will fund approximately the same number of jobs as was funded with $319.4 million, the sum available for the preceding 12-month period.

How do you propose to do this?"

Response.

The Fiscal Year 1984 appropriation of $317,300,000 will provide 62,082 jobs. The current appropriation of $319,450,000 provides 62,502 positions. The difference of 420 is only slightly more than 1/2 of 1 percent. In individual States that overall reduction generally represents a loss of very few authorized positions and we do not anticipate that any individuals will lose a job.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

Question:

"I would appreciate it very much if you would submit with your answers to the attached questions a description of the Department's major technical assistance to the contractors, over the period 1981-1983, which the Department agreed at the hearing to provide to the Subcommittee. The Department also agreed at the hearing to provide documentation of the Department's conformance with Section 503(a) and 505(a) of the Older Americans Act."

Response:

An important method for the provision of technical assistance and training to program sponsors is the Older Worker Bulletin system. Bulletins are routinely sent to program sponsors that contain information about the technical aspects of program operations, as well as grant requirements and rules. These bulletins also provide state-of-the art information. An average of about 15 have been sent out on an annual basis since 1981. In 1984 ten bulletins have been sent to date. The bulletins cover such topics as unsubsidized placements, coordination, and distribution of program resources.

Each program sponsor is assigned a Federal staff person who has responsibility for monitoring and providing technical assistance. Technical assistance is provided as a result of onsite reviews, project report analysis and response to phone inquiries. Onsite reviews are completed with the issuance of a monitoring report that frequently includes technical information designed to improve performance.

In 1981 a SCSEP working conference was held in Baltimore, Maryland. The conference's purpose was to provide technical assistance that would contribute to improving program operations. Virtually all SCSEP sponsors attended and participated in this conference. Another working conference was held in November, 1983 for experimental program grantees operating private sector projects under the authority of Section 502(e). The purpose of this meeting was to provide technical assistance related to managing projects in the private sector. Staff members have also participated in training sessions conducted by SCSEP sponsors.

The principal emphasis in our technical assistance effort is to improve program administration through better management of resources and to provide information on program regulations and procedures. It is up to our sponsors to provide the substantive technical services which are needed by participants. Therefore, it is at that level that training and employment expertise is most important.

QUESTIONS FOR PATRICK O'KEEFE FROM SENATOR CHARLES E. GRASSLEY

In regard to the Department's conformance with Sections 503(a) and 505(a). The contacts with the Administration on Aging have taken place at the agency level, rather than through the Secretary's office. We believe that this is an appropriate level of contact in view of the delegation of administrative authority for the Senior Community Service Employment Program to the Assistant Secretary for Employment and Training.

Senator GRASSLEY. I would like to know in a general way whether it is a fair statement that the Department of Labor has created more job slots and transferred more workers to the private sector in the last year than ever before.

Mr. O'KEEFE. It sounds very fair, sir.

Senator GRASSLEY. Well, you know, I do not want to put something in your mouth. If you cannot substantiate that, then I do not want you to——

Mr. O'KEEFE. Specifically in the title V program, Senator?

Senator GRASSLEY. Yes.

Mr. O'KEEFE. I think we have a higher level of enrollment right now, Paul, than previously.

Mr MAYRAND. Yes; the unsubsidized placement rate has gone up over the last year. It has gone up more substantively from 1981 to 1983. With regard to whether or not we have created additional jobs more last year than before, that is a function of the appropriation level.

We currently have 62,000 job slots. Now, that will support more enrollees than 62,000, but with this kind of a program that is always the case.

Senator GRASSLEY. Of course, it is very obvious that with more funding and more job slots we are going to create more, but there has also been more transition to the private sector?

Mr. MAYRAND. Yes.

Senator GRASSLEY. The report made by the General Accounting Office that I referred to earlier—and I assume that you were here at that particular time—says that the Labor Department has never conducted a formal evaluation of the title V program as it presently operates. If this is true, why has the Department never seen fit to evaluate the program?

Mr. O'KEEFE. Mr. Chairman, it is true that we have not conducted a formal evaluation in the sense of an impact evaluation. We have to point out in that context, though, that we do monitor the program regularly and, in that process, are assessing its performance.

Our evaluation priorities have really been drawn toward the larger programs that we have a responsibility for, and I have to say that it is in that context that we have not yet evaluated this program.

Senator GRASSLEY. Does this program operate under regulations at present, and if so when were those regulations written?

Mr. **O'Keefe**. I will ask Mr. Mayrand to fill in on this. There are some complications with respect to the regulations, Mr. Chairman.

Mr. **Mayrand**. The set of regulations which, in effect, are final were regulations that were promulgated back in 1976. subsequent to that, the Department moved forward to propose new regulations in 1980. Those regulations have never been finalized.

The difference between the two sets of regulations, I believe, is rather modest. There were no major changes proposed in the draft regs back in 1980.

Senator **Grassley**. Can I ask you why the Department has never completed the regulations that they started to implement current law?

Mr. **Mayrand**. That is a very fair question. It is due to a combination of, I suppose, other priorities within the Department and considerations relating to the future of the program several years ago.

With respect to the 1981 amendments for title V, my recollection is that they were very, very modest. There was one I remember where the Congress eliminated a particular clause in section 502 related to enrollees with poor employment prospects. That was certainly made quite clear and disseminated on various occasions to all of the sponsors as a signal, we thought, and still do believe, of the Congress' continuing interest in unsubsidized placements. I think the unsubsidized placement experience from 1981 to 1983 will attest to that. So that amendment, I think, certainly has been put into practice.

There was also another one you would certainly recall, Senator. Prior to 1981, the Secretary had an option as to whether or not there would be demonstration projects, pursuant to section 502(e). The 1981 amendments made that obligatory, and therefore the reason why we have currently 16 demonstration projects. So that was put into practice as a consequence of the 1981 amendments.

Senator **Grassley**. I would like to have you summarize for me the types of technical assistance the Department has provided to the States and to the sponsors, and to give some idea of the magnitude of this technical assistance.

I suppose maybe you could answer that in a general way now, but what I would like you to do is provide some systematic documentation to the committee on the technical assistance you have provided to the States and national sponsors since 1981.

Would it be better if you answered that all in writing?

Mr. **O'Keefe**. I think we can submit for the record, Mr. Chairman, a record of the kinds of technical assistance in that period, yes.

[The information referred to follows:]

TYPES OF TECHNICAL ASSISTANCE THE DEPARTMENT HAS PROVIDED TO THE STATES AND TO THE SPONSORS

An important method for the provision of technical assistance and training to program sponsors is through the Older Worker Bulletin system. Bulletins are routinely sent to program sponsors that contain information about the technical aspects of program operations, as well as grant requirements and rule. These bulletins also provide state-of-the art information and contribute to better program operations. An average of about 15 have been sent out on an annual basis since 1981. In 1984 nine bulletins have been sent to date. These bulletins cover such topics as unsubsidized placements, coordination, and distribution of program resources.

Each program sponsor is assigned a Federal staff person who has responsibility for monitoring and providing technical assistance. Technical assistance is provided as a result of onsite reviews, project report analysis or phone inquiries. Onsite reviews are completed with the issuance of a monitoring report that frequently includes technical information designed to improve performance.

In 1981 a SCSEP working conference was held in Baltimore, Maryland. The conference's purpose was to provide technical assistance that would contribute to improving program operations. Virtually all SCSEP sponsors attended and participated in this conference. Another working conference was held in November, 1983 for experimental program grantees operating private sector projects under the authority of section 502(e). The purpose of this meeting was to provide technical assistance related to managing projects in the private sector. Staff members have also participated in training sessions conducted by SCSEP sponsors.

The principal emphasis of our technical assistance effort is to improve program administration through better management of resources and to focus attention on program regulations and procedures. It is up to our sponsors to provide the substantive technical services which are needed by participants. Therefore, it is at that level that training and employment expertise is most important.

Senator GRASSLEY. I referred also previously to the General Accounting Office report where they described to the committee that the Labor Department maintains coordination, oversight, and monitoring, with relatively little involvement in the direct program operation.

I would like to repeat a question that I asked the General Accounting Office about what the Department of Labor does in the way of applying its employment expertise so that the States and national sponsors and enrollees benefit from that expertise.

Mr. O'KEEFE. Mr. Chairman, the Department has primary responsibility for administering the program. We turn to the States and the national contractors and grantees to organize and provide the substantive services to the participants.

It is in the context, going back to your earlier question, of our technical assistance as to where we will assist those State entities and the national grantees in improving their administration of the program. But I do not think that the Employment and Training Administration has a direct role in the provision of services to participants. That is not the way we view our responsibilities in the administration of the program.

Senator GRASSLEY. OK.

Mr. MAYRAND. I might say, Senator, that much of the technical assistance that is provided by the Federal partner is related to working particularly with national sponsors in developing and participating in their national training conferences, to which they also invite State sponsors.

So we do attend those conferences. We do participate as trainers, providing the Department of Labor's perspective on what the program should do, and that is rather constant.

Senator GRASSLEY. How many people do you have involved with that?

Mr. MAYRAND. At the present time, the staffing for this particular program is 10 individuals.

Senator GRASSLEY. Is that what they do with most of their time, then, is the kind of technical help to the sponsors as you just suggested?

Mr. MAYRAND. A large part of their time is spent responding to inquiries and providing technical assistance over the telephone. That is always a large part of their workload during the day.

Beyond that, a considerable amount of time is spent reviewing all of the quarterly reports that must be submitted by both national and State sponsors—quarterly reports on the fiscal performance and quarterly reports on the enrollment levels, the characteristics of the enrollees. Those reports are reviewed. It is a form of exercising oversight.

If there are problems identified, or what we may perceive as a problem, then the individual Federal staff person will get on the phone and talk to the sponsor. This is over and above of the technical assistance that would be provided in the normal course of going onsite to monitor a program.

Senator GRASSLEY. I would like to refer to section 503(a) of the act where it requires the Secretary of Labor to consult, through the Commissioner on Aging, with the State agencies on aging and the appropriate area agencies on aging with regard to several aspects of the program operations, and then there are several listed there, as you know.

Section 505(a) also requires consultation and requires the Secretary to obtain written views of the Commissioner. My question is whether or not you have done this, and can you provide us with documentation of those consultations?

Mr. **Mayrand**. There is no formal documentation we could provide. When we went through the rulemaking process for the 1980 regulations, we did obtain written comments from the Commissioner on Aging.

There is usually no less than telephonic contact with the staff of the Administration on Aging in terms of what is happening with the program. There is obviously considerable contact between the State offices on aging and the national sponsors on the equity situation.

There has never been an attempt to do other than provide the Administration on Aging anything that they have requested from us.

Senator **Grassley**. Well, in a more specific way, let me ask it this way. Has Secretary Donovan ever talked to the Commissioner on Aging about this program?

Mr. **Mayrand**. Assistant Secretary Angrisani has on various occasions, I believe.

Mr. O'**Keefe**. I cannot speak to whether or not the Secretary has, Senator.

Senator **Grassley**. Well, would you find out and submit it in writing?

Mr. O'**Keefe**. We will ask about that, yes.

[Information supplied for the record follows:]

The contacts with the Administration on Aging have taken place at the agency level, rather than through the Secretary's office. We believe that this is an appropriate level of contact in view of the delegation of administrative authority for the Senior Community Service Employment Program to the Assistant Secretary for Employment and Training.

Senator **Grassley**. Thank you. I think the rest of my questions I am going to have to submit to you in writing as well. I want to thank you very much for your being so candid. Thank you.

Mr. O'**Keefe**. Thank you for having us.

Mr. **Mayrand**. Thank you.

Senator **Grassley**. Our next witness is Katie Dusenberry. She is chairman of the Reauthorization Committee of the Federal Council on Aging, and is a county supervisor in Arizona. I am also aware of the fact that she is a graduate of Iowa State University.

Ms. **Dusenberry**. How did you find that out?

Senator **Grassley**. We have ways. There are no secrets among Iowans.

Would you please go ahead with your testimony?

STATEMENT OF KATHRYN DUSENBERRY, CHAIRPERSON, REAUTHORIZATION COMMITTEE, FEDERAL COUNCIL ON THE AGING, ACCOMPANIED BY EDWARD MARCUS, STAFF DIRECTOR, FEDERAL COUNCIL ON THE AGING

Ms. Dusenberry. Thank you, Senator Grassley. Good morning, and thank you for the opportunity to appear before you this morning.

As you have said, I am Katie Dusenberry, chairperson of the 1984 Reauthorization of the Older Americans Act Committee of the Federal Council on the Aging, and, in addition, a local elected official, being a county supervisor in Pima County, AZ. I am also on the board of directors of the National Association of Counties.

My jurisdiction in Arizona includes the greater Tucson area. The views that I am expressing this morning support the platform language of the National Association of Counties, and they have asked me to indicate that to you because this testimony is in line with their platform language.

The Federal Council on the Aging has submitted along with this testimony the complete text of our recommendations, and in view of time constraints, I will briefly summarize our findings and recommendations, particularly concerning title V.

Currently, funding for the title V programs is dispersed among eight national organizations, all of which you have heard from this morning, and the Governors of the various States and territories.

This arrangement results in some States with as many as six national organization sponsors as well as State-sponsored programs, and States with as few as one sponsor. Three States are served only by the State agency.

With the number of actors involved, coordination is a major problem, in our view, with the title V structure. Current statute briefly addresses coordination at both the State and Federal level. You have just quoted from the act that the Federal legislation instructs the Secretary of Labor, through the Commissioner of the Administration on Aging, to consult with the State agencies in determining localities of need, capacities of eligible individuals and communities, and the number of eligibles in the local communities.

As I have looked at what is happening in my State, I find that none of these programs prior to coming to the State coordinated to determine localities of need, capacities or numbers of eligibles in the various communities.

The same statute instructs national organization sponsors to submit a description of planned projects within the State to the State agency for review and comment to assure efficient and effective coordination.

Department of Labor regulations state each project sponsor shall, to the maximum extent feasible, cooperate with each project sponsor operating in the same State. However, contact that we have made with various State and local area agencies has indicated that although the spirit of cooperation is present in both statute and regulation, everyday operation does not reflect significant coordination.

This January, for instance, in my own State for the first time our State agency, which is contracting with a national sponsor for operation of a program in our State, called the administrators of the various programs together, but effective coordination has not really been taking place within my State.

In arguing for retention of the title V programs as currently administered, the national organizations claim effective program management by pointing to high service statistics and low administrative costs. When new job slots are allotted, national organizations have had a tendency to add those slots in areas already served by their ongoing projects.

This lowers the cost of administration; there is no doubt about that. However, it tends to leave blocks of underserved individuals in the more isolated areas. It has been the experience of a number of State-sponsored programs that it becomes their responsibility to pick up these pockets of underserved persons, thus increasing the administrative costs for State-sponsored programs.

Particularly, I think, in providing local match efforts, some of the administrative costs are provided in those matching efforts and do not reflect total expenditures, and it does give the picture of low administrative costs in those instances.

In addition to the coordination concern, issues have arisen with regard to the Department of Labor regulations under title V. The Department of Labor has interpreted a clause of title V calling for innovative approaches to training and moving individuals into private employment as a mandate for setting quotas on the number of persons transitioned into unsubsidized employment.

Current Department of Labor regulations call for 15 percent of the program participants in each project to be transitioned each year. This national goal does not take into account the great variability that exists among the programs.

Employment needs differ not only among the older individuals within a community, but also from one community to another. Ethnicity, culture, and socialization influence individual circumstances. Local economic conditions and geographic settings affect the ability of a community to respond to those differences in circumstances.

Although training programs naturally lead to encouragement for unsubsidized employment, the determination of the number of participants capable of this type of transition more appropriately lies at the local level, where the training occurs and the realistic employment prospects are better known.

In view of the foregoing, the Council recommends that the oversight responsibilities of title V should be shifted from the Department of Labor to the Administration on Aging to bring these programs in line with the majority of the Older Americans Act's programs. This move would facilitate the coordination of programs at the State and area agency level by greatly strengthening the working relationship between the employment projects and the other Older Americans Act programs.

Statutes and regulations now read that State and area agencies have only a consultative role in the title V programs with regard to projects which are managed by the national sponsors. Currently, there appears to be a minimum effort toward local coordination by the national projects with the area agencies on aging, particularly with regard to development and implementation of the national title V projects, as well as the area plans.

Responses from a number of State and local area agencies on aging have indicated that the mechanisms needed to administer the additional job slots are already in place in their agencies in most instances. These agencies frequently administer the slots allotted to the Governors, and therefore do have the experience to oversee such programs.

Our State and local area agency in Arizona would bring integration, prioritization, and realistic individual assessment to the program. The Council feels that bringing the administration of title V under the auspices of the Administration on Aging, while temporarily continuing the current participation of the national contractors as well as the State sponsors, could be done with little disruption.

The funding mechanism of grants as is used in the Older Americans Act for title IV projects would enable the program to be moved gradually into the Administration on Aging over a 2-year period. In the third year, funding would shift to that mechanism used in title III, with the funds flowing through the State and local units on aging based on title III formulas.

Thank you for the opportunity of bringing this testimony to you.

[The prepared statement of Ms. Dusenberry and responses to questions submitted by Senator Grassley follow:]

FEDERAL COUNCIL ON THE AGING
WASHINGTON, D.C. 20201

STATEMENT OF

KATHRYN DUSENBERRY

CHAIRPERSON OF THE 1984 REAUTHORIZATION OF

THE OLDER AMERICANS ACT COMMITTEE

OF THE FEDERAL COUNCIL ON THE AGING

BEFORE THE SUBCOMMITTEE ON AGING

COMMITTEE OF EDUCATION AND LABOR

UNITED STATES SENATE

MARCH 13, 1984

GOOD MORNING SENATOR GRASSLEY AND MEMBERS OF THE SUBCOMMITTEE ON AGING. THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE THIS SUBCOMMITTEE THIS MORNING. I AM KATIE DUSENBERRY, CHAIRPERSON OF THE 1984 REAUTHORIZATION OF THE OLDER AMERICANS ACT COMMITTEE OF THE FEDERAL COUNCIL ON THE AGING. IN ADDITION, I AM A COUNTY SUPERVISOR FOR PIMA COUNTY (ARIZONA) AND I AM ON THE BOARD OF THE NATIONAL ASSOCIATION OF COUNTIES. MY JURISDICTION AS A COUNTY SUPERVISOR INCLUDES THE GREATER TUCSON AREA.

AUTHORIZED BY THE OLDER AMERICANS ACT, THE FEDERAL COUNCIL ON THE AGING HAS BEEN IN EXISTENCE FOR OVER 10 YEARS. OUR 15 MEMBER BODY SERVES AS AN ADVISORY BODY TO THE PRESIDENT, THE SECRETARY OF HEALTH AND HUMAN SERVICES, THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES, THE U.S. COMMISSIONER ON AGING, AND THE CONGRESS REGARDING THE SPECIAL CONCERNS OF OLDER AMERICANS. THE COUNCIL HAS WIDE LATITUDE IN APPROACHING ITS MISSION, WHICH INCLUDES THE EVALUATION OF FEDERAL POLICIES AND PROGRAMS, COLLECTION AND DISSEMINATION OF INFORMATION, AND HOLDING PUBLIC HEARINGS OR SEMINARS REGARDING THE NEEDS AND PROBLEMS OF OUR OLDER POPULATION.

IN 1982, THE FEDERAL COUNCIL ON THE AGING ESTABLISHED A COMMITTEE ON THE 1984 REAUTHORIZATION OF THE OLDER AMERICANS ACT. THIS COMMITTEE HAS BEEN WORKING FOR SOME TIME NOW IN ANTICIPATION OF THE 1984 REAUTHORIZATION. IN ADDITION TO LOOKING AT CURRENT ISSUES, THE COMMITTEE RE-EXAMINED THE STUDY AND RECOMMENDATIONS MADE BY THE FCA FOR THE 1981 AMENDMENTS.

AFTER IDENTIFYING A NUMBER OF IMPORTANT ISSUES, THE FCA CONDUCTED A ROUNDTABLE DISCUSSION IN DECEMBER 1982 WHERE THIRTEEN NATIONAL AGING ORGANIZATIONS MADE PRESENTATIONS. CONCERNS WITH THE ADMINISTRATION OF TITLE V PROGRAMS WERE AMONG THE MAJOR ISSUES THROUGHOUT THE ROUNDTABLE DISCUSSIONS. A POLLING BY MAIL OF 35 ADDITIONAL ORGANIZATIONS THAT DEAL WITH AGING ISSUES REVEALED OTHER ITEMS, INCLUDING THE QUALITY AND AVAILABILITY OF RESEARCH INFORMATION. ADDITIONAL MEETINGS WITH CONGRESSIONAL STAFF, STATE AND AREA AGENCY STAFF, AND CONTACTS AT VARIOUS LOCAL CONFERENCES AROUND THE COUNTRY YIELDED CONSIDERABLE INTEREST IN THE SHIFT OF RESPONSIBILITY AND DISCRETION IN DECISION-MAKING TO THE STATE AND LOCAL LEVELS. AS A RESULT OF THESE ACTIVITIES, WE DEVELOPED A NUMBER OF RECOMMENDATIONS THAT WE FELT WERE RESPONSIVE TO CONCERNS THAT WERE BEING ARTICULATED BY THE AGING NETWORK.

IN 1983, THE COUNCIL MADE TWO PUBLIC PRESENTATIONS OF OUR DRAFT RECOMMENDATIONS, ONE AT THE ANNUAL MEETING OF THE WESTERN GERONTOLOGICAL SOCIETY IN ALBUQUERQUE, NEW MEXICO, AND THE OTHER AT THE ANNUAL SCIENTIFIC MEETING OF THE GERONTOLOGICAL SOCIETY OF AMERICA IN SAN FRANCISCO. IN BOTH INSTANCES WE SOLICITED AND RECEIVED COMMENTS AND RECOMMENDATIONS CONCERNING THE OLDER AMERICANS ACT. THE COUNCIL'S RECOMMENDATIONS WERE FINALIZED IN DECEMBER 1983 AND TRANSMITTED TO THE PRESIDENT IN EARLY JANUARY 1984. THE COUNCIL HAS DISTRIBUTED COPIES OF OUR RECOMMENDATIONS TO INTERESTED PARTIES, INCLUDING ALL MEMBERS OF THIS SUBCOMMITTEE.

WE HAVE SUBMITTED, ALONG WITH THIS TESTIMONY, THE COMPLETE TEXT OF OUR RECOMMENDATIONS. IN VIEW OF TIME CONSTRAINTS, I WILL BRIEFLY SUMMARIZE OUR FINDINGS AND RECOMMENDATIONS CONCERNING TITLE V.

CUURENTLY, FUNDING FOR THE TITLE V PROGRAMS IS DISBURSED AMONG EIGHT NATIONAL ORGANIZATIONS (NATIONAL CENTER ON BLACK AGED, NATIONAL URBAN LEAGUE, ASOCIACION NACIONAL PRO PERSONAS MAYORES, NATIONAL COUNCIL ON THE AGING, AMERICAN ASSOCIATION OF RETIRED PERSONS, NATIONAL COUNCIL OF SENIOR CITIZENS, U.S. FOREST SERVICE, AND GREEN THUMB-NATIONAL FARMERS UNION) AND THE GOVERNORS OF THE VARIOUS STATES AND TERRITORIES. THIS ARRANGEMENT RESULTS IN SOME STATES WITH AS MANY AS SIX NATIONAL ORGANIZATION SPONSORS AS WELL AS THE STATE-SPONSORED PROGRAMS, AND STATES WITH AS FEW AS ONE SPONSOR. THREE STATES ARE SERVED ONLY BY THE STATE AGENCY.

WITH THE NUMBER OF ACTORS INVOLVED, COORDINATION IS A MAJOR PROBLEM IN THE TITLE V STRUCTURE. CURRENT STATUTE BRIEFLY ADDRESSES COORDINATION AT BOTH THE STATE AND FEDERAL LEVELS. FEDERAL LEGISLATION INSTRUCTS THE SECRETARY OF LABOR TO, "THROUGH THE COMMISSIONER OF AOA, CONSULT WITH THE STATE AGENCY" IN DETERMINING LOCALITIES OF NEED, CAPACITIES OF ELIGIBLE INDIVIDUALS AND COMMUNITIES, AND THE NUMBERS OF ELIGIBLES IN THE LOCALITIES.

UNTIL THIS YEAR, IN MY STATE OF ARIZONA, THERE WERE 3 OF THE NATIONAL CONTRATORS PROVIDING PROGRAMS -- THE LARGEST IS NCOA WHO CONTRACTS WITH 2 AGENCIES. THESE ARE OUR OWN STATE DEPARTMENT OF ECONOMIC SECURITY, WHICH ADMINISTERS OUR STATE DOLLARS, AND THE INDIAN DEVELOPMENT DISTRICT OF ARIZONA WHICH SERVES 12 TRIBES OF NATIVE AMERICANS. THE NATIONAL FOREST SERVICE AND GREEN THUMB WITH A SMALL NUMBER (30 SLOTS) OF PARTICIPANTS IN A PROGRAM IN THE FAR REACHES OF THE COLORADO RIVER, IN YUMA, LA PAZ, AND MOJAVE COUNTIES ARE THE OTHER 2 NATIONAL CONTRACTORS. THIS YEAR FOR THE FIRST TIME, AFTER THE ADMINISTRATION BEGAN CONSIDERATION OF AOA ADMINISTERATION OF TITLE V, THE ASOCIACION NACIONAL PRO PERSONAS MAYORES BEGAN A PROGRAM IN SOUTHERN ARIZONA. THEY CONTRACTED WITH OUR LOCAL CATHOLIC SOCIAL SERVICES AGENCY TO ADMINISTER 90 SLOTS. NONE OF THESE PROGRAMS HAVE, PRIOR TO COMING TO THE STATES, COORDINATED TO DETERMINE LOCALITIES OF NEED, CAPACITIES OR NUMBERS OF ELIGIBLES IN VARIOUS LOCALITIES.

THE SAME STATUTE INSTRUCTS NATIONAL ORGANIZATION SPONSORS TO SUBMIT A DESCRIPTION OF PLANNED PROJECTS WITHIN THE STATE TO THE STATE AREA AGENCY FOR REVIEW AND COMMENT TO "ASSURE EFFICIENT AND EFFECTIVE COORDINATION". DOL REGULATIONS STATE "EACH PROJECT SPONSOR SHALL, TO THE MAXIMUM EXTENT FEASIBLE, COOPERATE WITH EACH OTHER PROJECT SPONSOR OPERATING . . . IN THE SAME STATE". HOWEVER, CONTACTS WITH VARIOUS STATE AND LOCAL AREA AGENCIES HAVE INDICATED THAT ALTHOUGH THE SPIRIT OF COOPERATION IS PRESENT IN BOTH STATUTE AND REGULATION, EVERYDAY OPERATION DOES NOT REFLECT SIGNIFICANT COORDINATION.

THIS JANUARY IN MY STATE, FOR THE FIRST TIME, OUR STATE AGENCY CALLED THE ADMINISTRATION OF THESE PROGRAMS TOGETHER SO THEY COULD BEGIN TO COMMUNICATE. PERHAPS IT HAS BEEN OUR DISCUSSION OF CHANGE THAT HAS BROUGHT ATTENTION TO THIS SECTION OF THE STATUTES. BUT "EFFECTIVE COORDINATION" HAS NOT BEEN TAKING PLACE.

IN ARGUING FOR RETENTION OF THE TITLE V PROGRAMS AS CURRENTLY ADMINISTERED, THE NATIONAL ORGANIZATIONS CLAIM EFFECTIVE PROGRAM MANAGEMENT BY POINTING TO HIGH SERVICE STATISTICS AND LOW ADMINISTRATIVE COSTS. WHEN NEW JOB SLOTS ARE ALLOTTED, NATIONAL ORGANIZATIONS HAVE HAD A TENDENCY TO ADD THOSE SLOTS IN AREAS ALREADY SERVED BY THEIR ONGOING PROJECTS. THIS LOWERS THE COST OF ADMINISTRATION. HOWEVER, IT TENDS TO LEAVE BLOCKS OF UNDERSERVED INDIVIDUALS IN THE MORE ISOLATED AREAS. IT HAS BEEN THE EXPERIENCE OF A NUMBER OF STATE SPONSORED PROGRAMS THAT IT BECOMES THEIR RESPONSIBILITY TO PICK UP THESE POCKETS OF UNDERSERVED PERSONS, THUS INCREASING THE ADMINISTRATIVE COSTS FOR STATE SPONSORED PROGRAMS.

OR WORSE YET, IN MY COMMUNITY, THE LOCAL AREA AGENCY ON AGING HAS FOR MANY YEARS HANDLED PAYROLL SERVICES FOR THE STATE CONTRACT WITH NCOA, WITHOUT ANY COMPENSATION FOR THAT ADMINISTRATIVE SERVICE. THIS SHIFTS THE ADMINISTRATIVE COSTS FROM THE ACCOUNTING IN THE NCOA CONTRACT TO ANOTHER PROGRAM FOR THE ELDERLY.

IN ADDITION TO THE COORDINATION CONCERN, ISSUES HAVE ARISEN WITH REGARD TO DOL REGULATIONS UNDER TITLE V. THE DOL HAS INTERPRETED A CLAUSE OF TITLE V CALLING FOR INNOVATIVE APPROACHES TO TRAINING AND MOVING INDIVIDUALS INTO PRIVATE EMPLOYMENT AS A MANDATE FOR SETTING QUOTAS ON THE NUMBER OF PERSONS "TRANSITIONED" INTO UNSUBSIDIZED EMPLOYMENT. CURRENT DOL REGULATIONS CALL FOR 15 PERCENT OF THE PROGRAM PARTICIPANTS IN EACH PROJECT TO BE TRANSITIONED EACH YEAR. THIS NATIONAL GOAL DOES NOT TAKE INTO ACCOUNT THE GREAT VARIABILITY THAT EXISTS AMONG THE PROGRAMS. EMPLOYMENT NEEDS DIFFER NOT ONLY AMONG THE OLDER INDIVIDUALS WITHIN A COMMUNITY BUT, ALSO, FROM ONE COMMUNITY TO ANOTHER. ETHNICITY, CULTURE, AND SOCIALIZATION INFLUENCE INDIVIDUAL CIRCUMSTANCES. LOCAL ECONOMIC CONDITIONS AND GEOGRAPHIC SETTING AFFECT THE ABILITY OF A COMMUNITY TO RESPOND TO THOSE DIFFERENCES IN CIRCUMSTANCES. ALTHOUGH TRAINING PROGRAMS NATURALLY LEAD TO ENCOURAGEMENT FOR UNSUBSIDIZED EMPLOYMENT, THE DETERMINATION OF THE NUMBER OF PARTICIPANTS CAPABLE OF THIS TYPE OF TRANSITION MORE APPROPRIATELY LIES AT THE LOCAL LEVEL WHERE THE TRAINING OCCURS, AND THE REALISTIC EMPLOYMENT PROSPECTS ARE BETTER KNOWN.

IN VIEW OF THE FOREGOING, THE COUNCIL RECOMMENDS THAT THE OVERSIGHT RESPONSIBILITIES FOR TITLE V SHOULD BE SHIFTED FROM DOL TO AOA, TO BRING THESE PROGRAMS IN LINE WITH THE MAJORITY OF OAA PROGRAMS. THIS MOVE WOULD FACILITATE THE COORDINATION OF THE PROGRAMS AT THE STATE AND AREA AGENCY LEVEL BY GREATLY

STRENGTHENING THE WORKING RELATIONSHIP BETWEEN THE EMPLOYMENT PROJECTS AND THE OTHER OAA PROGRAMS. STATUTE AND REGULATIONS NOW READ THAT STATE AND AREA AGENCIES HAVE ONLY A CONSULTATIVE ROLE IN THE TITLE V PROGRAMS WITH REGARD TO THE PROJECTS WHICH ARE MANAGED BY THE NATIONAL SPONSORS. CURRENTLY THERE APPEARS TO BE MINIMUM EFFORT TOWARD LOCAL COORDINATION BY THE NATIONAL PROJECTS WITH THE AREA AGENCIES ON AGING, PARTICULARLY WITH REGARD TO DEVELOPMENT AND IMPLEMENTATION OF THE NATIONAL TITLE V PROJECTS AS WELL AS THE AREA PLAN. RESPONSES FROM A NUMBER OF STATE AND LOCAL AREA AGENCIES ON AGING HAVE INDICATED THAT THE MECHANISMS NEEDED TO ADMINISTER THE ADDITIONAL JOB SLOTS ARE ALREADY IN PLACE IN THEIR AGENCIES IN MOST INSTANCES. THESE AGENCIES FREQUENTLY ADMINISTER THE SLOTS ALLOTTED TO THE GOVERNORS AND, THEREFORE, DO HAVE THE EXPERIENCE TO OVERSEE SUCH PROGRAMS.

OUR STATE AND AREA AGENCIES IN ARIZONA WOULD BRING INTEGRATION, PRIORITIZATION AND REALISTIC INDIVIDUAL ASSESSMENT TO THE PROGRAM. PRESENTLY THE NATIONAL CONTRACTORS' COORDINATOR IN PIMA COUNTY OPERATES ON A FIRST-COME, FIRST-SERVED METHOD OF FILLING SLOTS. THERE IS LITTLE JOB TRAINING, JOB DEVELOPMENT, OR MATCHING OF INDIVIDUAL NEEDS TO SPECIFIC JOBS. I FEEL THESE JOB SLOTS SHOULD BE PLACED IN OUR COMMUNITIES AND IN OUR STATES AS CAREFULLY AS WE PLACE MONEY AS A RESOURCE -- BECAUSE THEY ARE MONEY.

THE COUNCIL FEELS THAT BRINGING THE ADMINISTRATION OF TITLE V UNDER THE AUSPICES OF AOA WHILE TEMPORARILY CONTINUING THE CURRENT PARTICIPATION OF THE NATIONAL CONTRACTORS AS WELL AS THE STATE SPONSORS COULD BE DONE WITH LITTLE DISRUPTION. THE FUNDING MECHANISM OF GRANTS, AS IS USED BY AOA FOR TITLE IV PROJECTS, WOULD ENABLE THE PROGRAM TO BE MOVED GRADUALLY INTO AOA OVER A TWO YEAR PERIOD. IN THE THIRD YEAR, FUNDING WOULD SHIFT TO THAT MECHANISM USED IN TITLE III, WITH THE FUNDS FLOWING THROUGH THE STATE AND LOCAL UNITS ON AGING BASED ON THE TITLE III FORMULA. IN ADDITION, DEFINING EMPLOYMENT NEEDS SHOULD BE ENCOURAGED AT THE LOCAL LEVEL WITH A MORE FLEXIBLE PLACEMENT PRACTICE RESPONSIVE TO LOCAL AND INDIVIDUAL DIFFERENCES, REGARDLESS OF ANY SHIFT IN ADMINISTRATIVE OVERSIGHT.

MR. CHAIRMAN, THIS CONCLUDES MY PREPARED REMARKS. THE FEDERAL COUNCIL ON AGING WELCOMES THIS OPPORTUNITY TO SHARE ITS VIEWS WITH THIS SUBCOMMITTEE. I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

QUESTIONS FOR KATIE DUSENBERRY FROM SENATOR CHARLES E. GRASSLEY

Question 1: You say in your reauthorization statement that coordination is a problem in the Title V structure: the GAO report did not find coordination problems in states they visited. Is this a matter of the blind people and the elephant? And if so, do we need a more systematic survey to determine whether there is a coordination problem and, if so, what the extent of it is?

FCA Response: From the work done by the Federal Council on the Aging staff in early 1983 concerning the coordination issues of the Title V programs, we found that a problem does exist. When Area Agencies on Aging were contacted regarding their coordination and contact with the national contractors, many of them responded that they had never been contacted by the representatives or officials of the national contractors and that in many cases, slot placements by the contractors were not consistent with area plans that were prepared by the AAAs.

The national contractors assert that coordination is not an issue in the functioning of Title V programs. The GAO report did not find it to be a problem because they did not talk to the Area Agency staff, nor did they look specifically at the issues of coordination. The GAO report states in its methodology section (page 2, last paragraph):

> "In order to determine the results and benefits from the current program operation, we concentrated on four quantifiable goals targeted in Title V of the Older Americans Act or Labor program regulations. These goals related to participant eligibility, administrative and matching costs, transitioning enrollees to private sector jobs, and using available funds to enroll the maximum number of older persons. We reviewed program data provided by Labor, the national and state sponsors and local project officials to determine if these objectives were being met . . ."

Since the Council began discussions of the transfer of administrative oversight of the Title V programs from the Department of Labor (DOL) to the Administration on Aging (AoA), FCA staff has been told of AAAs being approached by local officials of the national contractors on the issue of coordination. I believe this would not have occurred without this discussion of coordination between the AAAs and the national contractors, as well as the Council's discussion regarding transferring the program from DOL to AoA.

I believe that we do need a more systematic study of the Title V program to specifically address the issues of coordination between the national contractors and the area agencies. As I mentioned in my testimony, in my home state of Arizona, the national contractors have only recently begun coordination with the state unit on aging and with each other.

Question 2: With respect to this coordination issue, would the Federal Council support a change in the law which required the state plan developed by the state agencies on aging to include a plan for the Title V program?

FCA Response: With respect to a requirement of the inclusion of a state plan concerning Title V by the state agencies on aging, the Federal Council on the Aging supports the position taken by the National Association of State Units on Aging (NASUA). Their position is to require a single Title V state operational plan, that would be developed by the states and the national contractors and submitted to the governors of each state. This plan would allow the states and contractors to work together and to jointly agree to an equitable distribution of slots that could be a first step towards achieving coordination among the various projects which are operating within an individual state. We stress that this must be a coordinated effort. In each state, that state, the AAAs, and the national contractors must plan together. The inclusion in state plans of a requirement for state sponsored programs alone would have little effect in solving the problems of coordination among the multiple sponsors of these programs.

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Question 3: You mentioned in your statement that you serve on the board of the National Association of Counties. We learned in our long-term care hearing in January that many triple-a's are located in county government. Are you able to tell us what the feeling of county government is on the question of whether there is adequate coordination between the national sponsors and the states and triple-a's in this program?

PCA Response: Most of the Area Agencies on Aging that are part of county government are also members of the National Association of Area Agencies on Aging (N4A). Both N4A and the National Association of Counties (NACo) have expressed their concern for the issues of coordination of the Title V program to the Council staff.

County governments that are also Area Agencies on Aging experience similar situations as other AAAs. There are two major concerns of the counties. The first is the lack of equitable distribution of slots throughout a region. The second is that when new slots are given to the national contractors, they are often placed in existing service areas, leading to the unequitable distribution.

Question 4: You mentioned that in your community the local Area Agency on Aging has for many years handled, without compensation, payroll services for the state contract with NCOA. Is this sort of practice widespread to your knowledge?

FCA Response: The example I sp[illegible] of in my own Area Agency on Aging (Pima Council on Aging) w[illegible]st one example of the different types of arrangements [illegible]he Title V program. Other cases of this type probably do [illegible]t, but I do not know to what extent.

Recent N4A studies have pointed to the fact that 57% of the AAAs in the country are administering Title V programs, either a state sponsored program or with funds from the national contractors. The data from the N4A did not address the issue of AAAs providing services to the national contractors without compensation. It is an area that should be further explored, perhaps as part of a GAO study.

Senator GRASSLEY. Would you introduce your associate? I am sorry I did not have you do that at the beginning.

Ms. DUSENBERRY. I am sorry; I should have. Ed Marcus is the staff director for the Federal Council on the Aging.

Senator GRASSLEY. You have been very helpful to us, I know, or at least somebody in your position has been in the past.

Mr. MARCUS. Thank you.

Senator GRASSLEY. Thank you. I am not going to take time, because I am running just a little bit late, but I have four questions that we want responses to and I would ask you before you leave for my staff to consult with you so that you know specifically what we want to ask.

Ms. DUSENBERRY. Fine.

Senator GRASSLEY. Thank you very much for your testimony.

Ms. DUSENBERRY. Thank you.

Senator GRASSLEY. Our last witness is a constituent of my colleague from Maryland, Senator Paul Sarbanes. He has asked the committee to receive Billye McGaharn's testimony, and also requested that the following statement be made a part of the record, and I will read from a statement on Senator Sarbanes' stationery on the introduction of Ms. Billye McGaharn, director of the Area Agency on Aging, St. Marys County, MD.

Senator Sarbanes says this:

> Chairman Grassley, although I am unable to be present today, I would like to introduce to you and the other members of the Senate Labor and Human Resources Committee Ms. Billye McGaharn, director of the Area Agency on Aging, St. Marys County, MD, who will present testimony on title V of the Older Americans Act.
>
> Ms. McGaharn has been the director of the Area Agency on Aging in St. Marys County for the past 8 years. She has had a career as a public school educator and presently is a doctoral candidate at American University and a college instructor, in addition to her responsibilities at the St. Marys County Area Agency on Aging.
>
> As one who has long been involved in serving the elderly in Maryland, she provides helpful insights into the title V program which has been so important in my State, and I am pleased that you and your staff have worked so graciously to provide her with the time to address the committee today.

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That is a very nice introduction from Senator Sarbanes and I know he appreciates the work you are doing. Would you proceed?

STATEMENT OF BILLYE McGAHARN, DIRECTOR, AREA AGENCY ON AGING, ST. MARYS COUNTY, MD

Ms. McGAHARN. Thank you. It is indeed a pleasure to be here with you today. I bring you greetings from St. Marys County. We have a little activity going on down there, you know, with the 350th, and I would certainly like to invite everybody to come down.

We are very proud of our county. We are a rural residential county with limited industries, causing limited employment opportunities—and that is why I am here today, gentlemen. I would like to discuss with you the title V program, and what it means to the older worker and also to the aging network across the country. It is not necessary to develop a wealth of background information since I know you know well older people. I have heard many very fine testimonies. You know the plight of older people. You know some of the considerations of area agencies and that there is not a great deal of money running around. You know, also, that we are searching continuously for manpower.

I am taking a little bit of a different slant today. In my written testimony, I told you exactly how important and how productive the older people are in St. Marys County. Of course, this is mentioned and repeated by many of my counterparts throughout the State and I am sure throughout the Nation.

I would like to go on record in asking that in your considerations you be very, very concerned about the number of job slots that come into the aging network. Specifically, in St. Marys County there are 14 slots. Now, I know that to some of the big metropolitan areas that does not sound like many and the amount of money that they save the county and the State does not sound like much, but for St. Marys County it is very important.

Older people who come to work in area agencies—present problems because the agency needs them and also because the older worker wants to stay. I know the direction of the title V program. I know that it is to get older people in unsubsidized employment, but I would like to have a greater look taken at the marketplace, looking at the number of older people who get into the market and businesses, and so forth.

I have heard some of your questions such as: What is the tracking record? How many older workers received unsubsidized employment? How many older people are now in employment in the private sector as compared to year one, two, three? How may older people were retained in employment more than 6 months?

I would say this: I have taken into my staff two positions. I mentioned to you I have 14 now, from whom I received last year. So, really, that record is not bad. These 14 employees were put into leadership roles and on substantive positions. They are doing a fine job for the agency.

I would like to think that the aging network has a great concern for older people, which we do, and I would like to think that the title V employment program is one of the greatest services made available to the elderly.

I find that the elderly who come to work in the area agency in St. Marys County are very reluctant to leave. They have found a niche; they are doing a good job. They are saving money for the Government, while helping other elderly of the county. They are not in welfare lines; they are not begging for anything. They want their jobs so they can retain independence as long as possible. What is wrong with that?

If some elderly employees do not move on so quickly to unsubsidized employment, they are productive and reducing costs for Government by serving frail elderly. They are useful and they are happy.

Another item of consideration for title V is quality of life. Are we truly offering older people a good quality of life by insisting that they move on to another area of work which they do not know so well?

Many of them have gone into the marketplace and they do not last long. Are we really doing what the Older Americans Act tells us to do? I leave that question. I will be open for questions, but I will leave that one hanging.

I listened to the business about equitable distribution; I listened to percentages. I do not hear that language. I hear older people who are happy doing a job and making other older people happy. What is wrong with older people helping other older people? Is that not the kind of independence that we want for this particular segment of the population?

Then, talking about equitable distribution, which considers geographical location and its density factors. We talk about percentages. What about the rural areas? Do we really show good, equitable distribution in the rural areas?

We do not have many job markets in rural areas. We do not have unsubsidized businesses to market employment. We do not really have many people compared to New York, California, and some of those places. But our older people hurt just as much; even though they are fewer in number, they hurt just as much as the bigger areas which have bigger numbers and get bigger numbers of older people to work.

So, when we are talking about equitable distribution, what does that mean? I do not know.

The true, living picture and the one major request I ask of this body today is let us look at percentage of job slots which are moved into the aging network. Let us boost that number up and let us not be too concerned if they do not move to unsubsidized employment too fast because they surely are doing a good job where they are.

I could go on. It is a subject that is dear to my heart, but in the interest of time I would like to stop and thank you very much for your attention.

[The prepared statement of Ms. McGaharn and additional material supplied for the record follow:]

Testimony of Billye McGaharn

St. Mary's County

Area Agency on Aging

Reauthorization of Title V of the Older American's Act

Presented March 13, 1984

Title V of the Older American's Act has supported employment of 55+ workers for many years. Some of these workers are placed within the aging network, lending support to programs for the elderly.

A major thrust of the Older American's Act is to move older workers into unsubsidized positions after receiving on-the-job training from sponsoring agencies. Unfortunately, meeting the mandate of transition from public assistance to unsubsidized employment is a difficult mandate to enforce from two points of view.

Vast needs for manpower exist in the aging network. Therefore, when manpower is available, aging agencies, such as local Offices on Aging, easily absorb the manpower as part of existing staff.

Once incorporated, the older worker feels comfortable and needed and is reluctant to move on to other areas where his services may not be met with a comparable level of approval. The aging agency also wishes to retain the older worker because they are providing services which the agency cannot fund. Also a camaraderie exists since aging agencies are equipped to deal with older workers, knowing well their needs, capacities and incapacities.

Area Agencies are constantly caught in an unenviable position of meeting the mandate of pushing older workers into unsubsidized job opportunities. Frustrations exist because of lack of employment markets, bias of employment of the elderly, and also because of inadequate skill potential and/or physical incapacities of the older worker. This struggle represents a catch 22 for Area Agency on Aging directors called upon to advocate mainstreaming, developing an environment for independence, and assuring the best possible quality of life for older people. Much of the latter sentence can be summed up into the word, self-help — meaning older people making their way with their own money from their own job.

Title V provides jobs for older workers around the nation. In St. Mary's County 7 Senior Aides and 7 Green Thumbers are working for $3.35 an hour for 20 hours a week. The income a typical worker receives under this program approximates $4,000 a year.

The program returns to the economy far more than its cost. For example, inhome services allow frail older people an opportunity to remain in their own home at less cost to themselves and the government than institutionalization in a nursing home.

Cost effectiveness of the program in St. Mary's County can be noted in the following:

Title V Annual Summary

Senior Aides - 7
Green Thumb - 7
14

14 x 20 hrs./wk. x $3.35 hr. x 52 wks. = $48,776.00

Production

Senior Aides - 7 77,778 units/yr.
Green Thumb - 7 65,032 units/yr.
142,810

Cost per unit of service .34.

These figures are based on quarterly reports, but many older workers work beyond the working day in volunteer capacity. Also, contributions are made to service areas in which older people work; therefore, monies are reported through services for which older workers' efforts have assisted in collecting. If a different method of calculation were used, unquestionably savings to local aging agencies would spiral upward.

The 14 older workers are employed in the following manner:

Transportation Number	Transportation - Bus Drivers Salary	Production Units
4	$13,936	29,280
	Food Transporter	
1	$3,484	36,150
	Inhome Services	
8	$27,872	55,502
	Nutrition Assistant	
1	$ 3,484	21,876

Since the Older American's Act was written to bring about a better quality of life for older people, it seems only reasonable that Title V, dedicated to employment of the older person should have priority with older person programs. It further is reasonable that staff dedicated to serving older people can develop better training packages, and also working environments free from ageism.

I speak today for St. Mary's County where older workers are a significant part of the staff, delivering services to people in need while fulfilling their own needs for added funds.

The points I make for St. Mary's County, however, can be replicated throughout the country. The aging network is desperately in need of additional funding resources, and Title V represents such a resource.

Population figures for older people have skyrocketed, yet funding amounts have not skyrocketed. The needs of the elderly have continued to increase, intensifying with age. In St. Mary's County, the population of elderly currently is 6,753 — of this number 16% are highly impaired. They require much care in the home. If Title V were not in existence, chances are the level of care for these elderly would be restricted, since all 7 aides in inhome services are Title V funded.

A need exists to have more slots in the aging network. Increased population brings about increased needs requiring increased manpower. I respectfully request that the number of slots for the aging network be increased to a minimum of 25%.

It behooves all of us to allow older people the opportunity to support themselves in a job - especially when that job assists in meeting a primary goal of the Older American's Act —— dignity and self-respect through productive, independent living for the nation's elderly.

RESPONSE OF THE NATIONAL COUNCIL ON THE AGING, INC. TO TESTIMONY PRESENTED BY KATHRYN DUSENBERRY BEFORE THE SENATE SUBCOMMITTEE ON AGING OF THE LABOR AND HUMAN RESOURCES COMMITTEE

In testimony before the Senate Subcommittee on Aging of the Labor and Human Resources Committee on March 13, 1984, Kathryn Dusenberry, representing the Federal Council on Aging, and identifying herself as a County Supervisor for Pima County, Arizona, and a Board Member of the National Association of Counties, made comments regarding the Title V Senior Community Service Employment Program (SCSEP) administration and operations in Arizona, with a particular focus on National Council on the Aging, Inc. (NCOA) operations. Ms Dusenberry's testimony contained several inaccuracies and omissions, and we hope that this statement will provide clarification about our program as addressed in Ms. Dusenberry's presentation.

1. COORDINATION:

Ms. Dusenberry states "None of these programs have, prior to coming to the State (Arizona) coordinated to determine localities of need, capacities or numbers of eligibles in various communities." This statement is incorrect and does not adequately describe NCOA's long-standing role of positive coordination with the Arizona Aging and Adult Administration.

For instance, NCOA initially established a subcontract arrangement with the Arizona Department of Economic Security for the Fiscal Year 1974-5 period and has maintained this subcontract to the present time. The administrative unit within the Arizona Department of Economic Security (DES) which NCOA works with was initially the Bureau on Aging and currently is the Aging and Adult Administration. The relationships have been cordial and cooperative, resulting in continuing coordination.

2. DETERMINATION OF LOCALITIES OF NEED, CAPACITIES OR NUMBER OF ELIGIBLES IN VARIOUS COMMUNITIES.

The NCOA project in Arizona began with 30 job slots. The initial agreement for the project to be established on a state-wide basis under the administration of the Bureau on Aging was reached as a result of extensive discussions with Arizona DES and the Bureau on Aging. The decision was based on the following objectives:

a. To establish SCSEP positions throughout the State. To achieve this, the six Council of Government Planning Areas in Arizona were used as a basis for allocation of the 30 slots.

b. To provide for an orderly and coordinated assignment of job slots as the OAA Title IX/V program grew. The decision as to the number and location of job slots on an annualized basis was based upon growth of the program, the evaluation of demographic and needs assessments made by the Arizona Department of Economic Security and the pragmatic conditions affecting operations of a State-administered older workers program. The State of Arizona received Title V funds directly from the Department of Labor (DOL) in 1978 and an agreement was made between NCOA and Arizona DES that the NCOA slots would be confined to Maricopa and Pima Counties with the remaining State slots assigned to the four other planning areas. However, the two separately funded Title V programs under the administration of Arizona DES (NCOA/DOL) continued to operate as a unified program. This consolidated administration of the two programs assured maximum coordination between NCOA and the State.

There has also been coordination with other national sponsors; we will cite an example. Green Thumb originally established positions on the Navajo reservation. An agreement was reached between NCOA and Arizona DES that the NCOA contract with the Indian Development District of Arizona (IDDA) would serve eligible elderly Indians residing on reservations. A series of meetings involving NCOA, the

Arizona Department of Economic Security, the Indian Development District of Arizona, and Green Thumb resulted in the successful transfer of former Green Thumb enrollees on reservations to NCOA, and an agreement between Arizona DES and Green Thumb for Green Thumb to establish community based positions in planning areas under-served by the State. These positive adjustments were made with no disruption of services or dislocation of any enrollee. Another example occurred in the Spring of 1983, when the Asociation Nacional Pro Personas Mayores was establishing a new SCSEP site in Pima County, Arizona. NCOA initiated communication with the Arizona Department of Economic Security and the Asociation to assure coordination.

Ms. Dusenberry is correct that there has not been an annual meeting of contractors in Arizona. However, there has been regular communication so that all affected parties were knowledgeable as to the number location and sponsor of SCSEP job slots throughout the State of Arizona.

3. RELATIONSHIPS WITH STATE AGENCIES AND AREA AGENCIES ON AGING:

In Arizona, the contract between NCOA and the Arizona Department of Economic Security assures coordination. As a matter of national policy, NCOA coordinates its SCSEP activities with State Agencies and local Area Agencies on Aging. In Arizona, Area Agencies on Aging (AAA) have traditionally had the right and opportunity to make recommendations to the Arizona Department of Economic Security regarding utilization of enrollees, development of worksite agencies and community needs. On August 6, 1975, a meeting with AAA and Nutrition Directors was convened to discuss Title IX, NCOA policies and relationships. Since this planning meeting ten years ago, NCOA has continued to advocate for an effective partnership with AAAs, the State Agency on Aging, and other interested parties to assure maximum benefits for participating communities and older workers. In Tucson, there is a formal agreement by which the Council on Aging and Senior NOW agreed to designated the latter agency to be responsible for older worker programs such as the SCSEP.

We have conferred with Area Agencies on Aging in Arizona and elsewhere to solicit their linkages and recommendations. Some have done so; others have chosen not to respond to our invitation. NCOA fully supports the local Area Agencies on Aging performing the functions which are their responsibilities as authorized by the Older Americans Act.

4. ADMINISTRATIVE COSTS AND ALLOCATIONS:

The initial contract between NCOA and the Arizona Department of Economic Security provided for some of the administrative costs.

From the onset, in keeping with the requirement to secure matching funds, NCOA and DES agreed that DES would, to the extent possible, meet administrative costs and the NCOA funds would be used for enrollee wages, fringes and other enrollee costs. This objective was achieved and the same pattern continued after Arizona DES received SCSEP funds directly from the Department of Labor. In 1983, when the Department of Labor informed Arizona DES that it could no longer charge administrative costs for the NCOA portion of its Title V operation to the State grant. NCOA and Arizona DES came to a joint agreement to consolidate both grants into a single allocation under direction of NCOA. As a result of this cooperation, there is now one set of records for the combined NCOA/DOL programs. Administrative efficiency and effectiveness has been increased and paper work reduced. Further, the direct beneficiaries of this consolidated administration are the older workers recruited and placed in agencies throughout Arizona.

According to Ms. Dusenberry's testimony, the local Area Agency on Aging in Pima County "has for many years handled payroll for the State contract with NCOA, without any compensation for that administrative service. This shifts the administrative cost for the accounting in the NCOA contract to another program." In Arizona, the Department of Economic Security enters into a cost reimbursement contract with worksite agencies. The agency, which benefits from the presence of the enrollee, pays salaries, wages, fringes and other allowable costs directly to the enrollee. Upon receipt of proper documentation, Arizona DES reimburses the worksite agency. In Tucson, at various times there were worksite agencies which, for a variety of reasons, were unable to handle enrollee payrolls, etc. The Area Agency on Aging in Tucson, on a voluntary basis, agreed to payroll a limited number of enrollees. To our knowledge, the matter of administrative cost or burden was never raised as a problem. If it had been, in keeping with the requirement for local match and involvement, another agency would have been secured to assume this responsibility.

5. INDIAN DEVELOPMENT DISTRICT OF ARIZONA:

NCOA established a Senior Community Employment program with the Indian Development District of Arizona as its contractor in 1972. From the inception, the program was designed to serve all eligible elderly Indians residing on reservations in Arizona. All tribes, including the Navajo nation, are served by IDDA. The project was established because of the special needs which exist on reservations. The Arizona Department of Aging, NCOA and IDDA have coordinated their activities to assure non-duplication of effort and effective program operations throughout all reservations in Arizona.

SUMMARY:

The record in Arizona speaks for itself. There has been a continuing, close relationship between NCOA and the State agency. Project locations and the number of slots assigned to each project have been arrived at cooperatively. The NCOA funded project to serve Indian reservations has been operated in cooperation with the State agency. There has been coordination between NCOA, the State agency and other national sponsors within Arizona. Equitable distribution of enrollee slots has been a continuing goal, as additional slots become available.

Testimony Regarding
--Older American Act (Public Law 89-73)

Before The

LABOR AND HUMAN RESOURCES AGING SUBCOMMITTEE

UNITED STATES SENATE

March 13, 1984

Presented By

Joan C. Freund

Assistant Station Manager

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Mr. Chairman and distinguished members of the Labor and Human Resources Aging Subcommittee:

I am Joan C. Freund, Assistant Station Manager of the Wichita Radio Reading Service (radio reading for the print-handicapped, one-half of the listeners are over 55 years of age), and I am also involved in the gerontology program at Wichita State University, Wichita, Kansas.

Through my work and involvement in the gerontology program, I have has close personal contact with many older people who work. Based on these experiences I strongly urge your support in reauthorization of the Older Americans Act, Title V, Community Service Employment for Older Americans.

I wish to thank you for this opportunity to state my views regarding community service employment for older Americans.

The present bill not only provides low-income older Americans with the opportunity for employment, it also;

1) improves the income and living conditions of low-income older people,
2) by providing income it decreases the older person's dependency on public assistance,
3) provides the worker with fringe benefits, such as, workers compensation, liability insurance, etc.,
4) provides community service through specialized agencies, and
5) gives those older people who need to work economically or emotionally the right to work.

I have had the opportunity to work with and talk to several people who are involved in federally funded employment services for low-income elderly workers. Following is a discussion of three individuals whom I feel have benefited from working in federally funded employment programs for older workers. These programs are designed to promote supportive community service in social, health, education, and welfare. The names are changed to protect the identity of these individuals.

Mrs. A is a 76 year old black woman, who works in a day care center, 20 hours a week. She is provided liability insurance and transportation to and from work. Mrs. A wants to work because it gives her independence to live the way she choses. She uses the additional income to support herself in an apartment, pay the bills, etc. Without this added income she would have to live with her children or depend on the state for additional income.

Mr. B is a 70 year old white male who works with educable mentally handicapped children, 20 hours a week. He is also provided liability insurance and transportation to and from work. Mr. B works because the additional income is needed in his retirement years. He has worked most of his life as a farmer and the Social Security payment he receives is not enough to allow him to pay for the essentials of every day life; food, clothing, electric cost, etc. Without this added income he would have to rely on some form of in-kind support from the state. He is the only surviving member of his family and he has no children. His work not only provides a much needed income, it also gives him a chance to interact with others within the community.

Mrs. C is a 60 year old widow, also working 20 hours a week with educable mentally handicapped children. Her husband died after he retired, so she does receive some form of Social Security payment. She also receives, if needed, financial support from her children.

Mrs. C also wants to work. She has worked most of her life as a housewife and at odd jobs, and feels that working in her later years will help to keep her mentally and physically active. She is an alive, energetic, outgoing person who loves to work and who feels she has much to offer to her job and her community.

In each of these cases the additional income has improved the older persons financial status, and decreased their dependency on in-kind support from the state. The community service programs have provided work for older people who can and want to work. It has enable each of these people to maintain a sense of personal growth and self worth and allowed them to interact with others while providing a community service. These older people have shown that they can utilize their talents, skills and experience to benefit the community. Without the federally funded programs designed especially for older workers these people could not have worked.

We need these community service programs to guarantee the right of the older person to work. I urge your support in the continued funding of these programs under Title V of the Older Americans Act. Thank You.

Written Testimony of

Eugene S. Callender

Director, New York State Office for the Aging

submitted for inclusion in the hearing record of the

Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources

March 13, 1984, Hearing on Title V of the Older Americans Act

I appreciate the opportunity to submit recommendations for the reauthorization of Title V of the Older Americans Act, the Senior Community Service Employment Program. I believe it is critical that the aging network be provided with the authority and resources to increase gainful and useful employment opportunities for the Nation's low income elderly. In their struggle to enter or re-enter a tight labor force, these needy senior citizens face tremendous obstacles including age discrimination. The Senior Community Service Employment Program can help low-income elderly overcome these obstacles while providing essential community services.

I urge this Subcommittee to address three major issues in reauthorizing the Title V program:

--Increased State authority to coordinate programs;

--Provision of adequate resources; and

--Maintenance of the program in the U.S. Department of Labor.

Concern for older workers has been the hallmark of Title V program development and implementation. Any changes to the Title V program should spring from this single purpose.

In the area of coordination, expansion of linkages between Title V program sponsors and other employment and training organizations, both in the public and private sectors, are essential if the program is to remain an effective vehicle for older worker employment opportunities and career development in the Nation's increasingly competitive and technological labor market.

Since 1977, when the New York State Office for the Aging received its initial Title V grant, we have built our program from a few demonstration projects serving a modest number of economically disadvantaged older New Yorkers into a $4.6 million statewide program operating in all 62 of the State's counties through our 59 Area Agencies on Aging (including 2 Indian reservatrions) with an annual enrollee complement of more than 1,000 people. New York State's elderly Title V workers provide meaningful services in such capacities as outreach, job development and counseling, aging network support, long term care ombudsmen, energy assistance and weatherization, crime prevention, and in-home services.

In managing our Title V program during this period, the New York State Office for the Aging has cultivated highly productive and cooperative relationships with other employment-oriented organziations. Our ability to continue these relationships and to forge new ones has a direct and crucial bearing on appropriate referrals, assessments, training, and placement of older workers.

Among these organizations are five of the Title V national contractors based in New York State (Green Thumb, National Council on the Aging, National Retired Teachers Association/American Association of Retired Persons, National Council of Senior Citizens, and National Urban League), with whom we have successfully coordinated on such vital issues as equitable distribution of enrollee slots, position transfers, technical assistance, and training.

During the past two years, substantial cooperative efforts have been made with the New York State Department of Labor, particularly in the development and implementation of the Job Training and Partnership Act Title IIA Services and the 3% Older Worker Program. Among the more noteworthy accomplishments in this joint venture are: development and execution of agreements, applications, and guidelines; application review and recommendations; and provision of regional and older worker employment counselor training modules.

In the current program year, the New York State Office for the Aging, working with our Area Agencies on Aging, has undertaken a significant program initiative in developing and implementing experimental projects under Title V's Section 502(e). These projects are enhancing older worker employability in the private sector through innovative education and training modes such as on-the-job training, work experience, classroom training, job-sharing, and flex-time.

Over the years, the number and configurations of aging services network formal and informal working arrangements with other agencies including employment and training organizations, job service offices, and social service and health departments have increased by virtue of our staff's efforts to make new contracts. However, stronger statutory authority for State and Area Agencies on Aging to coordinate older worker employment activities would improve our ability to deal with other employment and training agencies, thereby expediting increased employment opportunities for older workers.

Notwithstanding good intentions and diligent efforts, the Title V program can do little without adequate funding. Although I recognize that a reauthorization bill cannot directly affect appropriation levels, I hope that your Committee report and legislative history will emphasize the needs in this area. I am troubled by the $2.5 million reduction in the FFY 1984 Title V program and the resultant decrease of 422 Title V jobs nationwide.

Since FFY 1980, the erratic pattern of decreases and increases in annual Title V appropriations has caused uncertainty and eroded stability and confidence among Title V enrollees, service beneficiaries, providers, and administrators about the program's fate. For example, when Congress overrode the President's veto of supplemental Title V funds in the fall of 1982, we viewed this vote as a strong expression of congressional intent to maintain program slots at their prior levels. Yet, based on a combination of updated population data and a mis-application of the statutory allocation formula, the New York State Office for the Aging Title V program lost 169 job slots despite the congressional override.

The New York State Office for the Aging allotment for FFY 1983 of $4,689,848 supporting 918 job slots has been pared down to $4,586,228 for 897 slots for FFY 1984, despite an increase in the State's elderly population. The loss of these job slots will result in a marked decline in New York State's ability to help older workers, if this practice of chipping away at program resources continues.

In your reauthorization of the Older Americans Act, I urge you to emphasize the need for increased appropriations for the Title V program, and to prevent reductions in allotments for successful State programs. Additional funding for the Title V program would be a convincing demonstration of a firm congressional commitment to improve the lives of older workers.

The third area I wish to address relates to the administrative locus of the Title V program. I hope that this Subcommittee rejects proposals to shift the program from the U.S. Department of Labor to the Administration on Aging (AoA) within the U.S. Department of Health and Human Services, and I make this recommendation despite occasional past problems (such as the mis-application of the distribution formula which I mentioned earlier) with Labor Department practices.

Although for some programs a transfer from one Department to another might not significantly affect efficiency or effectiveness, I believe that low-income elderly are better served by retaining Title V wholy in the Department of Labor. Transferring to AoA those components of the program administered by State Units on Aging, while leaving the national contractor portion with Labor, would surely weaken internal cohension of the program, diminish its integrity in comparison with other employment programs, and ultimately jeopardize job opportunities for older workers.

The U.S. Department of Labor is the primary agency responsible for employment and training programs. Within that department, Title V in its entirety can be more readily coordinated with other employment initiatives. This arrangement has already produced positive results.

In the fall of 1984, investigators from the General Accounting Office surveyed illustrative urban, suburban, and rural Title V programs operated in New York State, including those operated by the State Office for the Aging through Area Agencies on Aging and those operated by national contractors. Based on this investigation and many other factors, I understand that the General Accounting Office has observed that there are no hard data which would require shifting this program away from the Labor Department. With no clear gain from such a transfer, I urge this Subcommittee to reject the transfer proposal while protecting Title V coordination with other employment and training programs administered by the Department of Labor.

In closing, I wish to emphasize the importance of the Title V program as a fulcrum for State-level coordination and development of job training programs serving low-income elderly. Building on expertise developed through our administration of the Title V program, for example, the New York State Office for the Aging has initiated some new projects. Through a grant from the Governor's Office on Employee Relations and the State's public sector unions, we have established a Mature Worker Unit with an expert advisory board to help develop policies to assist older workers in New York State. Due to coordination between my office and the New York State Department of Labor, the State's Job Training Partnership Act plan also embodies a promising innovative approach to integration of concerns of older workers into local programs. We are currently developing a new pre-retirement project to produce and replicate effective training programs to help older workers still on the job prepare for the labor market realities which confront them.

Innovative projects of this nature can continue to result from a strong Title V program with effective State-level coordination and adequate funding. Because of the strong congressional support for the program which has been demonstrated in the past, I am confident that this Subcommittee will produce a reauthorization bill to further strengthen the Title V program and build on its past successes in helping low-income older Americans cope successfully with today's and tomorrow's job market.

Senator GRASSLEY. What percentage of total funding would you recommend, then, that would go into the aging network?

Ms. MCGAHARN. I understand from your comments that it is presently 22 percent.

Senator GRASSLEY. Yes.

Ms. MCGAHARN. I asked for a very minimal amount of 25 percent in my paper, and I said that as a minimum. I would always look upward.

Senator GRASSLEY. Yes. I am reminded that that was in the last paragraph of your testimony. You said a minimum of 25 percent.

Ms. MCGAHARN. Yes.

Senator GRASSLEY. Thank you very much for your testimony.

I want to say to the audience at large that this is the last of our hearings on all the titles of the Older Americans Act. We are going to move shortly, hopefully, to markup and I encourage all of you not only who are present in this hearing but in previous hearings to keep in touch with us as this happens.

We do need your expertise. We encourage dialog. Thank you very much. The meeting is adjourned.

[Whereupon, at 11:47 a.m., the subcommittee was adjourned.]

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